ABSTRACT

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Title: I Think I Might be in Over my Head: A Study of Counselor Ethical Decision-Making Patterns in Boundaries of Competence Concern Situations

Major: Counselor Education

Degree: Doctor of Education

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1/12/07

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ABSTRACT

The purpose of this qualitative grounded theory study was to explore ethical decision-making patterns of practicing professional counselors encountering boundaries of competence concerns. The study focused on boundaries of competence and ethical decision making. Using a random selection process, 725 licensed counselors in the state of Illinois were sent invitations to participate in the study. A total of 33 counselors responded to the invitations. Fourteen licensed counselors were selected to participate in the study. The primary research tool was a four-phase, face-to-face interview, which used a conceptual mapping exercise. The conceptual mapping exercise yielded very rich data.

During the conceptual mapping exercise, participants were asked to present a clinical case where, in the process of individual therapy, a boundaries of competence concern had emerged. After participants had selected and reviewed the relevant client case, they were asked to create a conceptual map spatially representing their process of decision making.

A research-based model for ethical decision making in boundaries of competence concern situations emerged out of the research data. No other research-based model or models specific to boundaries of competence concerns were found in the literature. It is therefore assumed that the emergent model is the first research-based model for ethical decision making to be presented to the profession. It is also

assumed that this is the first model specifically addressing boundaries of competence concern situations to be developed.

Many implications for counselors, supervisors, and counselor educators regarding the ethical decision-making process emerged from the data. Implications included consideration of a number of factors within the ethical decision-making process. These factors emphasized: (a) more direct consideration of the therapeutic relationship, (b) the potential impact of negative supervision and/or system dynamics impacting the decision-making process, (c) training and consideration for the possibility that clients will terminate the treatment process without allowing space and time for closure to the relationship, (d) the aftermath/post-outcome reflection stage as a potentially painful process, which may need specific attention by supervisors and counselors, and (e) consideration of the conceptual mapping task as a possible training, supervision, and research tool.

NORTHERN ILLINOIS UNIVERSITY

I THINK I MIGHT BE IN OVER MY HEAD: A STUDY OF COUNSELOR ETHICAL DECISION-MAKING PATTERNS IN BOUNDARIES OF COMPETENCE CONCERN SITUATIONS

A DISSERTATION SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

DOCTOR OF EDUCATION

DEPARTMENT OF COUNSELING, ADULT, AND HIGHER EDUCATION

BY

LINDA LEITCH-ALFORD

DEKALB, ILLINOIS

MAY 2007

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ACKNOWLEDGEMENTS

The patience, time, commitment, and expertise of the members of my dissertation committee is sincerely appreciated: Dr. Toni Tollerud, whose patient investment in my writing and scholarship skills has been invaluable. Dr. Fran Giordano, whose expertise in qualitative research coupled with notable enthusiasm for this particular study gave needed inspiration and guidance at many points along the way. Dr. Scott Wickman, whose expertise with style manual technicalities eased the task of manuscript preparation. Dr. Jim Sells, whose mentoring and encouragement laid the foundation needed for completion of this project in spite of the fact that his own career journey interrupted participation in this project.

Special thanks are extended to the 14 courageous professional counselors who volunteered to tell their stories. The richness of this study is a tribute to their commitment to professional growth and the counseling profession. Additionally, I want to acknowledge the joy I personally experienced in interviewing these professionals. They have increased my pride in being a member of the counseling community.

I offer my sincere gratitude to family members, friends, and colleagues, who patiently supported, encouraged, challenged, and inspired me throughout this project: My husband and daughters, whose love and presence is a treasure. My friends and colleagues, whose support and encouragement have sustained me. My supervisor,

Arlo, whose therapeutic skill and honesty sharpened my awareness of boundaries of competence concerns and provided the clear and sound guidance needed for clinical and ethical decision making.

Acknowledgement of the part my brother Gary, my friend Diane, and my colleague Andrew played in this dream becoming a reality is in order. Each of their lives was interrupted during the course of this project, but their inspiration did not end with their passing. My brother Gary spent the last months of his life facing death and praying his sister would successfully complete her dissertation. My friend Diane was a woman who lived a full personal and academic life. She consistently modeled a feminine energy that inspired me to begin and finish this task. My colleague Andrew was a principled and virtuous therapist, who inspired me to think deeply and "rightly" about clinical issues.

DEDICATION

With gratitude for my husband Tom, who is my companion and partner in life,

and in honor of my brother Gary, friend Diane, and colleague Andrew,

whose lives were interrupted during the course of this project

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CHAPTER 1

INTRODUCTION

Competence is foundational to the life of mental health professionals and critical to the vitality of their professions (Haas & Malouf, 1995; Herlihy & Corey, 1996; Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Remley & Herlihy, 2005). According to Van Hoose and Kottler (1988), therapists repeatedly find themselves working outside their area(s) of competence, because every client brings distinctly different concerns and personal dynamics to the treatment process. When counselors encounter a boundaries of competence concern, they must engage in a process of ethical decision making to determine a clinically and ethically sound course of action that will address the concern in question.

Straightforward or simple ethical decisions are part of everyday experience for professional counselors. Haas and Malouf (1995) reported that counselors take in an "enormous amount of information in the context of underlying 'operating principles'" (p. 7) on a daily basis and regularly make ethical choices almost without conscious thought. Whereas some situations are uncomplicated and draw only on ordinary moral understandings developed in everyday life, the mental health professional also faces increasingly complex ethical difficulties (Haas & Malouf, 1995, Kitchener, 1984b, 2000; Welfel, 2006). Complex situations, which have no obvious or simple answer, are known as ethical dilemmas (Kitchener, 1984b; Remley & Herlihy, 2005; Welfel,

2006). Boundaries of competence concerns often fall into the category of ethical dilemmas (Van Hoose & Kottler, 1988). For these complex situations counselors can turn to ethical decision-making models.

The struggle and complex balancing act involved in the ethical decision-making process is not an isolated story idiosyncratic to any one counselor's practice (Smith, McGuire, Abbott & Blau, 1991). Ethical decision making is a necessary and constant process within the practice of professional counseling (Kitchener, 1991; Van Hoose & Kottler, 1988). Concerns around issues of competence occur even with the most experienced therapists and may emerge at any stage of the therapeutic process (Leigh, 1998).

The competent practice of mental health professionals within ethical standards is core to the integrity of the profession and basic to building and maintaining public trust (Herlihy & Corey, 1996; Van Hoose & Kottler, 1988; Zibert, Engels, Kern & Durodoye, 1998). The clinician's process of ethical decision making needs to be based in both the integrity of the individual practitioner and the standards of the practitioner's professional organization (Bersoff, 1996; Remley & Herlihy, 2001). Cohen and Cohen (1999), and Meara, Schmidt, and Day (1996) argued that character and integrity of the individual applying ethical codes and agreed-upon moral principles is core to the ethical decision-making process (Cohen & Cohen, 1999; Meara et al., 1996), and they have called the counseling profession to attend to counselor virtue. Being a virtuous therapist involves the application of prudence or practical wisdom, integrity, respectfulness or being tolerant, trustworthiness or

conscientiousness, and compassion or care (Cohen & Cohen; Corey, Corey, & Callanan, 2007; Kitchener, 2000; Meara et al. 1996, Remley & Herlihy, 2001).

The purpose of this qualitative, grounded theory study was to explore ethical decision-making patterns reported by practicing professional counselors when encountering boundaries of competence concerns within an ongoing individual counseling relationship. Boundaries of competence and ethical decision making were the two focus points of this study. Although there are many types of ethical dilemmas, this study is singularly focused on boundaries of competence issues because of two lines of thought.

The fundamental and pervasive nature of competence in the practice of professional counseling is the first reason for selecting a focus on competence. Several authors (Corey et al., 2007; Kitchener, 2000; Remley & Herlihy, 2005; Welfel, 2006) have pointed out that ability to make sound ethical decisions and understand competence boundaries is fundamental to the ethical practice of professional counseling. It has been said (Haas & Malouf, 1995) that all sections of each of the ethics codes relate, at least to some degree, to issues of competency.

The second reason for selecting boundaries of competence as the focus for this study related to the paucity of information concerning boundaries of competence and ethical decision making available in the research and training literature. According to Koocher and Keith-Spiegel (1998), "there are relatively few published papers exploring conceptualizations of competent psychological practice, and those few are limited in scope" (p. 56). A review of counseling ethics literature over the past two

decades revealed only a few studies (Gibson & Pope, 1993; Golden & Schmidt, 1998; Haas, Malouf, & Mayerson, 1986; Hayman & Covert, 1986; Neukrug, Milliken, & Walden, 2001; Pope, Tabachnick, Keith-Spiegel, 1987, 1988; Pope & Vetter, 1992) that made even minimal reference to competence concerns within the numerous items researched. Only three studies (Glennon & Karlovac, 1988; O'Malley et al. 1988; Svartberg & Stiles, 1992) were found that dealt primarily with counselor competence. Twenty-eight models of ethical decision making were found in the literature, but no model specific to boundaries of competence concerns was found. All of the texts most commonly used for ethics training of professional counselors include a chapter on competency, but none of them offers a decision-making strategy for reaching resolution when counselors encounter boundaries of competence concerns in the treatment process.

BACKGROUND OF THE PROBLEM

When complex ethical concerns which have no obvious or simple answer are encountered in the midst of clinical settings, the situation is referred to as an ethical dilemma and requires the counselor to enter into an ethical decision-making process (Kitchener, 1984b; Remley & Herlihy, 2001; Welfel, 2002). The dilemma presents circumstances and calls for considerations for which there is no clearly charted course of action or guidance in the codes or the literature. Another distinction of ethical dilemmas is that they frequently involve conflict between two or more ethical principles or statements in the ethics codes. Consequently counselors are left with a

lack of clarity about where their major responsibility lies (Bersoff, 1996; Kitchener, 1984a; Remley & Herlihy, 2001). Kitchener (1984b) has described the ethical dilemma as "a problem for which no course of action seems satisfactory. The dilemma exists because there are good, but contradictory ethical reasons to take conflicting and incompatible courses of action" (p. 43). The mental health professional is frequently confronted with these complex, cloudy, and consequently, stressful ethical dilemmas (Corey, Corey, & Callanan, 1998; May & Sowa, 1992; Neukrug, Lovell, & Parker, 1996).

Therapists are automatically placed in a position of power as clients, who feel vulnerable due to diagnosable mental illness or some significant life disruption, enter counseling. The attempt to honor ethical responsibilities within this "disparity in power can complicate the task of counseling" (Carroll, 1997, p. 163). Although each of the mental health professions has set forth guidelines and standards for ethical practice, an "accurate application requires a thorough understanding of the details of each situation" (Carroll, p. 164).

According to Herlihy and Corey (1997), codes of ethics provide a guide for the practitioner that precipitates awareness of important issues, are a standard for professional accountability, and ultimately are designed to protect the public. Although codes provide a basis to instruct awareness of ethical conduct, it is the responsibility of the individual counseling professional to "develop a deeper understanding of the basis for ethical decision making" (Kitchener, 1984a, p. 4). However, ethical decision-making can be extremely complex, and often without a

clear right answer, leaving tremendous latitude for clinical judgment on the part of the individual practitioner (May & Sowa, 1992).

Each branch of the mental health profession has a stated code of ethics. The ethical code of reference for the professional counselor is published by the American Counseling Association (Welfel, 1998). Because the focus of this study was ethical decision-making patterns of professional counselors in relationship to competence or boundaries concerns, the *ACA Code of Ethics* (2005) was used as the primary code of reference. However, the researcher also referenced the *Code of Ethics of the American Mental Health Counselors Association 2000 Revision* (AMHCA), *National Board of Certified Counselors Code of Ethics* (NBCC) as amended in 2005, the 2001 *American Association of Marriage and Family Therapists Code of Ethics* (AAMFT), the American Psychological Association (APA) 2002 *Ethical Principles of Psychologists and Code of Conduct*, and the 1999 *Code of Ethics of the National Association of Social Workers* (NASW).

The concern that follows immediately in the discussion of boundaries of practice or competency issues is how the counselor can best proceed to follow ethical guidelines to reach resolution. Once professional counselors become aware of a potential competency concern, they are bound by ethical code to enter into an ethical decision-making process (Corey, Corey, & Callanan, 2003; Remley & Herlihy, 2001). Corey et al., as well as Remley and Herlihy, instruct counselors who are faced with limits of practice concerns to review their training on ethical decision making, seek

appropriate supervision, and give sufficient consideration to the many client dynamics around treatment, referral and/or termination.

Within the literature, there are a number of models proposed to assist the professional counselor in the ethical decision-making process (Cottone & Claus, 2000; Remley & Herlihy; Van Hoose & Kottler, 1988). Kitchener, in her seminal work published in 1984b, argued that counselors need to consider moral principles in the decision-making process. Moral principles (i.e. autonomy, nonmaleficence, beneficence, justice, and fidelity) are intended to assist the counselor in resolving ethical dilemmas when ethics codes and/or relevant literature do not specifically or sufficiently address their particular concern.

The integrity of the individual applying the principles is key to professional ethical conduct and decision making (Corey et al.,1998; Remley & Herlihy, 2001, Welfel, 1998). It is this notion that individual integrity is part of ethical decision making that leads to the discussion of virtue and principle ethics. Within the discussion of virtue and principle ethics Jordan and Meara (1990) distinguish the two as follows: "Typically, principles are used to facilitate the selection of socially and historically acceptable answers to the question 'What shall I do?' when confronted by ethical dilemmas. Virtue ethics, however, generally focus on the question 'Who shall I be?'" (p. 107).

The discussion concerning the need for virtues to accompany principles put forth by Jordan and Meara (1990) and Meara et al. (1996) called for more consideration of virtue ethics in the understanding of the application of professional ethics.

Considering the role of virtues and principles in the ethical decision-making process adds another dimension in the quest for understanding the criteria therapists rely on "when choosing among rationally justifiable alternatives in a dilemma" (Jordan & Meara, 1990 p. 112).

In their review of the literature on ethical decision-making models, Cottone and Claus (2000) gave a thorough presentation of the major models for ethical decision-making. They concluded that although there are a number of models available, there is little data to inform the use of these models. This study compared the components of ethical decision-making models present in the literature to the components practicing counselors reported using in ethical decision-making processes specific to boundaries of competence concerns.

STATEMENT OF THE PROBLEM

Case Illustration

Chris had been engaged in therapy with me for some time and by all measures seemed to be making significant progress. In the course of a complex life history and a multifaceted therapeutic journey, Chris had done both inpatient and outpatient therapy with a variety of different therapists. Chris reported that this time progress was really being made on some of the fundamental issues that often manifested themselves in serious life chaos. It was my assessment that this progress could be attributed in part to the fact that Chris had come to a place in his life where he was ready for change. I also

had a strong sense that something in the therapeutic relationship we had forged was contributing to Chris' current movement in therapy and newfound stability in life.

However, one day, deep into treatment, Chris reported a concern that began a significant struggle in our relationship. Chris had never broached this particular subject matter with me before. The newly spoken concern was a therapeutic area with which I had minimal familiarity and no developed skill. I was committed to this client and to his therapeutic process, but now felt uncomfortably "over my head" and began to struggle with some significant ethical principles. My struggle was with the pull of a strong commitment to Chris and the push of my belief that each and every client has the right to the best therapy possible. I wondered if I was the best therapist for Chris at this point. I knew I had an ethical obligation to know the limits of my competence and to practice within those limits.

I wondered about how to proceed in a manner that would provide the best possible treatment. Should I continue to see Chris and seek extra training and supervision? Would I be able to attain the needed skill level quickly enough so as not to cause harm? Would a referral process be experienced by the client as abandonment and thus cause harm no matter how carefully I managed the details? What other professional in the area would be better qualified, have the time and be willing to take on Chris? Given that Chris had no insurance and was seeing me at a reduced fee, how would a referral work out financially? If I could find someone better qualified in the area of concern who would be willing to see Chris for a minimal fee, how would I go about making this transition so as to cause the least amount of disruption to the

treatment process? If I were to continue to treat Chris, how would the new treatment plan differ and/or stay the same?

Chris and I discussed my concerns on several occasions, and my supervisor heard my struggle over and over again as Chris, my supervisor and I worked hard to understand the possible options and find the best solution to this dilemma. Over the course of several weeks the questions began to crystallize into a multidimensional understanding of a complicated consideration of balances. How could I juggle the honoring of the therapeutic relationship, my own professional limits, and the client's needs and desires while balancing what felt like conflicting statements within my professional code of ethics?

Decision Making in Boundaries of Competence Situations: A Complex Process

Within the mental health professions, a variety of situations produce difficult ethical dilemmas that propel clinicians into processes of ethical decision making. Encountering ethical dilemmas is an integral part of the work of the mental health professional (Bersoff, 1996; Mabe & Rollin, 1986; May & Sowa, 1992; Rest, 1986). One area of ethical conflict and challenge mental health professionals frequently face in the delivery of services occurs when the counselor is confronted with an awareness of a boundaries of practice concern within a given therapeutic situation (Remley & Herlihy, 2001; Van Hoose & Kottler, 1988). Counselor competence is a foundational issue in the professional practice of counseling. "When clients put their trust in us as

professionals, one of their most fundamental expectations is that we will be competent" (Pope & Vasquez, 1991, p. 51).

The ACA ethics code (2005) clearly states that "Counselors practice within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (C.2.a.). The complication is that competence is difficult to define and without a clear and comprehensive definition or measure within the mental health field (Koocher & Keith-Spiegel, 1998). It is a struggle for the professional counselor to assess precisely when he or she is exceeding his or her own boundaries of competence (Herlihy & Corey, 1996).

Within the mental health professions competency includes both the idea that clinicians are skilled, knowledgeable, and experienced in a stated area, and that they not impaired at the time services are delivered (Corey et al., 1998; Welfel, 1998). It is the ethical decision-making process of the professional counselor in relation to competency of skill, knowledge, and experience that is the focus of this study. Issues concerning impaired professionals, while important to the profession, are beyond the scope of this study. The case illustration of my work with Chris demonstrates the struggle and complexity involved in ethical decision making in the face of boundaries of competence concern situations relevant to this study.

NEED FOR THE STUDY

Meara et al. (1996) called for empirical research in regard to the practice of professional ethical thinking on virtue and principle ethics. They put forth the argument that ethics codes and ethical decision-making models are based primarily upon research about what ought to be and not on what is. It was their contention that the profession needs research on both what ought to be (i.e. how leaders in the field conceptualize sound ethical practice) and on what counselors are actually doing in the field.

In their comprehensive literature review of ethical decision-making models, Cottone and Clause (2000) concluded that the area of ethical decision making is in need of empirical research. They stated that, although the profession has a rich supply of models, a number of the models presented in the literature lack empirical support. Because little empirical research has been published on the topic of ethical decision-making models, Cottone and Clause have suggested that "the study of ethical decision-making models is immature" (p. 281).

Meara et al. (1996) and Cottone and Clause (2000) acknowledged that the literature offers plentiful instruction about what counselors should do when encountering ethical dilemmas, but suggested there is a scarcity of information about what counselors actually do in the process of ethical decision making. They pointed out that research is needed to inform the counseling profession about what is actually being done by counselors when they enter an ethical decision-making process. The paucity of research directly related to boundaries of competence found in the literature

and the lack of ethical decision making guidelines specific to boundaries of competence dilemmas was outlined earlier in this chapter. This study was conducted to respond to the apparent vacuum in the literature concerning what counselors are actually doing in response to situations that call for decision making in specific boundaries of competence situations.

PURPOSE OF THE STUDY

Once counselors become aware of a potential boundaries of competence concern situation, they are required to enter into an ethical decision-making process (Corey et al., 1998; Remley and Herlihy, 2001). The purpose of this study was to explore the ethical decision-making patterns used by professional counselors to resolve boundaries of competence concerns. Although mental health professionals are regularly confronted by ethical dilemmas and are often faced with boundaries of competence concerns situations in individual, marital and group counseling, this study will be limited to the work of practicing professional counselors in regard to the practice of individual counseling.

RESEARCH QUESTIONS

This study will examine the following research questions in regard to ethical decision making and limits of practice considerations.

1. What ethical decision making model emerges from the data as the professional counselor outlines the process she or he follows to resolve a

boundaries of competency concern?

2. What are the similarities and differences that emerge between the novice (LPC) and experienced (LCPC) counselor as they engage in the ethical decision-making process as it relates to a boundaries of competency concern?
3. Once a decision has been made to continue to treat or to refer, how does the practicing professional counselor implement the decision, and what are the similarities and differences between the novice and experienced counselors' approach to decision implementation?
4. How does the ethical decision-making process of the practicing professional counselor compare with the ethical decision-making models currently found in the literature?

SIGNIFIANCE OF THE STUDY

Although this study only approached one small area of ethics, it adds to the literature regarding the process of ethical decision making from the viewpoint of the practicing clinician. By focusing on the individual reports of counselors, the study begins to address the gap between the "what ought" and "what is" discussion in the literature and adds empirical data to the discussion of ethical decision-making models. This study analyzed what counselors actually reported experiencing in their ethical decision-making processes related to boundaries of competence concern situations and compared it to what the literature says counselors ought to do when encountering a boundaries of competence dilemma.

This was not an outcome study and, consequently, can not be used to validate particular models and/or their various components. The goal of this study was investigating the patterns of decision making used by practicing professional counselors to resolve boundaries of competence concerns. The data collected, analyzed and reported in this study provides counselors, counselor educators, and supervisors with practical information concerning the process of ethical decision-making in boundaries of competence issues situations.

LIMITATIONS OF THE STUDY

The perceived limitations of this study are listed below in bullet-pointed format. The listed limitations relate to design and include consideration of participant ability to identify a boundaries of competence concern, acknowledgement of possible participant memory alterations, possible implications of geographical limits, and effect of researcher on generation of research data. Additionally, it is recognized that this data only relates to counselor-reported experience and does not include client-reported experience.

- Participants needed to have an awareness of boundaries of competence issues and be able to identify their limits in at least one clinical experience. This was not a study to determine if counselors are aware of and/or can identify boundaries of competence issues. Therefore, the study does not address the issue of a general understanding of boundaries of competence among practicing professional counselors.

- It is acknowledged that each participant reported the stories of his or her selected clinical case that were impacted by his or her individual personal and professional experiences, professional training and level of development, and/or personal values and internalized virtue. Additionally, it is impossible to measure the degree of real memory disturbed by time.
- This study did not involve a national search, and, consequently, there may be inherent limits in the geographically restricted sample.
- It is acknowledged that researcher presentation and skill level may have impacted participant responses and contributed to what is called the "Hawthorne effect" (Cook & Campbell, 1979, p. 39).
- This was not a client outcome study and, therefore, there is no way of knowing client experience of the reported decision-making processes.

DEFINITIONS

Several terms that appear frequently in this study are defined in this section. Terms referenced in identifying the counselor, ethics and ethical decision making, selected elements related to ethical decision making, boundaries of competence and related considerations, and the conceptual mapping task research tool are defined in this section.

Counselor/Professional Counselor: Counselor and professional counselor are used interchangeable in this study, and refer to individuals who have completed at least a master's degree in counseling or a closely related program.

Ethics: Ethics, or moral philosophy, is a branch of philosophy that strives to understand and explain the complexities of moral behavior, moral dilemmas, and moral judgments (Frankena, 1963; Kitchener, 2000; Miller, 1983; Pojman, 1995; Remley & Herlihy, 2005; Tjeltveit, 1999).

Ethical Dilemmas: Complex situations which have no obvious or simple answer are known as ethical dilemmas (Kitchener, 1984b; Remley & Herlihy, 2001; Welfel, 2002). It is generally agreed that ethical dilemmas involve several common factors (Hill, Glaser, & Harden, 1995; Kitchener, 1984b, 2000; Rollins, 1997; Van Hoose, 1986). (1) The dilemma presents circumstances and calls for considerations for which there is no clearly charted course of action or guidance in the codes or the literature. (2) There is more than one possible solution and each of possible solutions, although all potentially valid, may flow from contradictory ethical reasoning. (3) Simple reference and adherence to the codes cannot solve the difficulty because in these complex and troubling situations the codes often are silent and/or present contradictions.

Ethical Decision Making: The process counselors engage in to resolve an ethical concern.

Ethical Decision-Making Models: Specific approaches to resolving ethical dilemmas requiring decision-making guidelines outside what codes are designed to address (Hill, 2004a; Neukrug, Lovell, & Parker, 1996)

Virtue Ethics: Virtue ethics generally focus on the question "Who shall I be? (Jordan & Meara, 1990, p. 107) and are about "the actor rather than the action"

(Remley & Herlihy, 2001). The five most agreed-upon virtues can be grouped as prudence or practical wisdom, integrity, respectfulness or being tolerant, trustworthiness or conscientiousness, and compassion or care (Corey et al., 2007; Kitchener, 2000; Remley & Herlihy, 2001).

Moral Principles: "The agreed upon assumptions or beliefs about ideals that are shared by members of the helping professions" (Remley & Herlihy, 2005, p. 7). Typically, principles are used to facilitate the selection of socially and historically acceptable answers to the question "What shall I do?" (Jordan & Meara, 1990, p. 107). The four most commonly agreed-upon moral principles within the counseling community are autonomy, nonmaleficence, beneficence, and justice.

Therapeutic Relationship: The interactive bond between client and counselor that has "specific tasks and goals to accomplish to help clients resolve problems" (Hill & O'Brian, 1999, p. 35).

Supervision: Any activity involving counselors seeking clinical guidance from a senior member of the profession or a peer for purposes of gaining clinical insight, direction, and/or furthering professional growth. In this study supervision included formal supervisor-led individual and group formats, informal peer networking experiences, and structured peer groups.

System: Any structured organization (i.e. agency or institution) established to provide social services and/or counseling to clients.

Boundaries of Competence: Codes of ethics specify that ethical counselors practice within their boundaries of competences. Counselors are mandated to be

diligent in assessing their knowledge, training, skills, abilities, and level of experience in order to determine their competence level. License, formal specialty credentialing, and standard of care are three indicators of counselor level of competence (Hill, 2004; Welfel, 2006).

Conceptual Mapping: A method of spatially representing relationships between concepts that is used to link complex ideas (Deshler, 1990).

Conceptual Mapping Task (CMT): The conceptual mapping task, which was introduced into counseling research by Martin in the 1980s (Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989), is a two-phase process. The first phase is "a free-association task used to generate a number of concepts" (Cummings, Hallberg, Martin, Slemon, & Hiebert, 1990, p.121). The second phase involves creation of a conceptual map using the concepts generated in phase one.

SUMMARY

Ethical counselors practice within the boundaries of their competence (Remley & Herlihy, 2005). When counselors encounter boundaries of competence concerns in the course of ongoing treatment, they are required to enter into an ethical decision-making process (Van Hoose & Kottler, 1988). The focus of this study was on ethical decision-making patterns of practicing professional counselors in relation to boundaries of competence concern situations.

Fourteen licensed counselors in the state of Illinois volunteered to share their stories of decision making from one selected client case that had raised competence

concerns for them. Data was collected in face-to-face interviews using the conceptual mapping task format introduced into counseling research by Martin (Martin et al., 1989). A research-based model for ethical decision making emerged from the data gathered during the face-to-face interviews. The data gathered for this study provides a wealth of practical information for counselors, supervisors, and counselor educators.

CHAPTER 2

REVIEW OF RELATED LITERATURE

The purpose of this study was to explore the ethical decision-making process used by licensed professional counselors to resolve ethical dilemmas when encountering boundaries of competence concerns. The material in this chapter is divided into four major sections that review relevant literature. The first section is an overview of the foundations of ethics and professional practice. It begins with a brief review of philosophical foundations underlying professional counseling ethics and concludes with a discussion of applied ethics. The second section is a review of ethical decision making. It includes a survey of the ethical decision-making process, an overview of ethical decision-making models, and a discussion of common components found in models of ethical decision making. Section three presents an overview of literature that addresses boundaries of competence issues and ethical decision-making dynamics specific to the emergence of boundaries of competence concerns. Section four is a review of the conceptual mapping research tool used to conduct this study.

FOUNDATIONS OF ETHICS AND PROFESSIONAL COUNSELING

Philosophical Foundations Underlying Professional Counseling Ethics

Ethics or moral philosophy is a branch of philosophy that strives to understand and explain the complexities of moral behavior, moral dilemmas, and moral judgments

(Frankena, 1963; Kitchener, 2000; Miller, 1983; Pojman, 1995; Remley & Herlihy, 2005; Tjeltveit, 1999). According to Rosenbaum (1982), all issues related to ethics emanate from efforts to understand "what is good and what is evil" (p. 1). Those who study ethics primarily concern themselves with principles and norms that should ideally govern human behavior and interaction. Daubner and Daubner (1970) and Van Hoose and Kottler (1988) pointed out that those who study ethics primarily focus on what human conduct *ought* to be rather than what *is*.

According to Pojman (1995), there are some who have questioned the practical benefits of ethics or moral philosophy. Pojman, however, offers the following argument promoting the functional relevance of ethics and the study of moral philosophy.

> It can free us from prejudice and dogmatism. It sets forth comprehensive systems from which to orient our individual judgments. It carves up the moral landscape so that we can sort out the issues in order to think more clearly and confidently about moral problems. It helps us clarify in our minds just how our principles and values relate to one another, and, most of all, it gives us some guidance in how to live. (p. xxi)

Tjeltveit (1999) observed there are some who would limit the understanding of ethical thought to the professional philosopher. However, Tjeltveit argued that within the field of professional counseling, leaving ethical thought to the professional philosopher neglects significant foundations of professional development and practice. A basic starting point in the interface between philosophy and the practice of professional counseling are the many theories of psychotherapy which professional counselors use daily which "do in fact rest upon fundamental philosophical positions and assumptions" (Miller, 1983, p. 212). According to Drane (1982), it is well

established that the work of professional counselors calls for regular ethical understanding and decision making. Drane further pointed to the tasks of client evaluation and clinical judgment, which are basic to the practice of professional counseling, to demonstrate the foundational and consistent presence ethics have within therapeutic relationships. Furthermore, there is significant agreement within the field of counselor education that study of ethics is essential to counselor preparation in the ethically complex world of clinical practice (Corey, Corey, & Callanan, 2007; Hill, 2004b; Remley & Herlihy, 2005; Welfel, 2006).

Defining Ethics

Ethics is concerned with questions important to human interaction, understanding and justifying of human conduct, and discerning moral decision making. Beauchamp and Childress (2001) defined ethics as a "generic term for various ways of understanding and examining the moral life" (p. 4). According to Tjeltveit (1999), ethicists address a wide range of questions about right and wrong as related to human life and behavior. Ethics also encompass discussions of virtue and how values play out in human conduct and interaction (Tjeltveit). Additionally, Wolman (1982) noted ethics is non-existent outside of relationship because morality is, by its very nature, about how individuals relate to one another.

According to Van Hoose and Paradise (1979), moral decision making is central to the study and application of ethics. Additionally, Van Hoose and Paradise pointed out the primary concern of ethics involves situations in which individuals have the

opportunity to select between two or more possible plans of action. The development of principles that will assist in guiding human actions and produce virtuous character is fundamental to ethics and ethical decision making (Pojman, 1995).

A thorough discussion of the philosophical designations of good and bad is beyond the scope of this review, as are complex discussions concerning understanding and assessing moral behavior. In-depth discussions concerning these matters can be found in a variety of texts referenced in mental health literature (Browne, 1973; Drane, 1982; Frankena, 1963; Pojman, 1995; Stein, 1990; Tjeltveit, 1999; Van Hoose & Kottler, 1988; Van Hoose & Paradise, 1979).

According to a number of authors (Kitchener, 2000; Remley & Herlihy, 2005; Tjeltveit, 1999; Van Hoose & Kottler, 1988; Wolman, 1982), the terms "ethics" and "morality" are often used interchangeably within counseling literature. However, in reviewing the current counseling literature concerning ethics and mental health professionals, the terms "moral" or "morality" were rarely found. Therefore, this study and literature review will use the term "ethics" unless a particular author referenced chooses the terms "moral" or "morality," in which case these terms will be honored.

Before concluding this overview of the definition of ethics, a word about the distinction between ethics and law is in order. Some equate ethics and law since they are often closely related (Corey et al., 2007; Remley & Herlihy, 2005; Welfel, 2006); however, there are important distinctions between the two. Law is intended to govern the affairs of individuals in a defined locale such as a nation, state, or city. Laws are designed to define freedoms and prohibitions for behavior and are enforceable with

specified consequences. This degree of authoritative exactness, which is present in the legal realm, is absent in the much broader domain of ethics (Corey et al.; Pojman, 1995; Remley & Herlihy; Van Hoose & Kottler, 1988; Welfel). Welfel pointed out that, at least in a democracy, the law applies to all inhabitants equally, but the application of ethical principles is not necessarily consistent within or across nations, states, or cities.

Ethical Theory

Van Hoose and Kottler (1988) argued that individuals acquire a set of ethical principles based on culture, and through the developmental process every individual, whether client or counselor, "ultimately develops a personal 'style' of ethics" (p. 24). Stein (1990) contended that all individuals have some personal ethical standards which guide their behavioral choices. The study of ethics and the development of an ethical theory promotes and even requires deep and conscious thought about human actions and interactions (Stein). The development of an ethical theory enables a person to evaluate and discuss ethical situations with maturity and integrity (Pojman, 1995). Frankena (1963) believed becoming an autonomous moral agent and developing a personal ethical theory involves moving from being unconsciously directed by cultural mores to thinking critically about moral actions.

In 1963, Frankena defined morality as a social institution traditionally transmitted though cultural formats which define rules, behaviors, and goals for living. Since that time others (Daubner & Daubner, 1970; Van Hoose & Paradise, 1979) have

argued the culture we live in no longer prescribes moral behavior as a comfortable, concise, well-defined, and broadly consistent spectrum out of which one can easily develop a personal ethical theory. Individuals have an array of contrasting moral choices to select from in many areas of modern life. Van Hoose and Paradise contended that it is possible to manage ethical life successfully within this atmosphere of ethical diversity, if individuals develop a personal clarity about their own behavior and select a set of guidelines for ethical living.

Drane (1982) and Pojman (1995) stressed moral philosophy is about more than generating and being able to cite guiding principles for human behavior. Moral philosophy also concerns building a theory about human conduct, interactions, the good life, moral obligation, and choices (Drane; Pojman). According to Pojman, "ethical theory clarifies relevant concepts, constructs and evaluates arguments, and guides us on how to live our lives" (p. xvi). Van Hoose and Paradise (1979) believed the study of ethics and the development of an ethical theory assists counselors in developing a personal and professional framework for scrutinizing ethical arguments. Beauchamp and Childress (2001) caution that developing ethical theory is a complex matter and advise tempering attempts to define right and wrong with the realization that "no moral theorist or professional code of ethics has successfully presented a system of moral rules free of conflicts and exceptions" (p.15).

Selected Psychotherapy Applications of Ethical Theory

Van Hoose and Kottler (1988) selected three approaches to ethics which they

found relevant to the work of counselors. The three approaches are based on the hedonistic position, self-realization theories, and moral development theories. These three approaches serve as examples of the influence philosophical ethics have had upon psychological theory. However, as Miller (1983) noted, it is critical for counselors to understand that psychological theory based on ethical positions brings forth ethical and/or clinical judgments. Miller also pointed out that these judgments, out of which therapeutic interventions and goals are created, are often stated as fact when in reality they are judgments and theories based in philosophical questions.

Hedonistic Position

"If it feels good, do it!" (Van Hoose & Kottler, 1988, p. 26). This summation of the utilitarian philosopher's orientation is, according to Van Hoose and Kottler, likely the most dominant popular understanding of ethics. Asking what is best for clients is important to a full discussion of the hedonistic position. Of course, this discourse must include some consideration of how what is best for individuals gets determined, as well as who decides what is best for individual clients.

Van Hoose and Kottler (1988) believed the influence of Freud and his instinctual-psychoanalytic theory has contributed to the popularity of a utilitarian approach to ethics. They also contended behaviorist approaches to therapeutic intervention are based on these principles of rewards and immediate pleasure fulfillment. According to Van Hoose and Kottler, "the commonsense hedonist

approach to ethics has far-reaching implications for understanding human behavior and making ethical decisions" (p. 26).

Self-Realization Theories

What Van Hoose and Kottler (1988) grouped together as the self-realization theories emerge out of the humanistic and existential philosophies expressed by such writers as Aristotle, Abraham Maslow, Erich Fromm, and Rollo May. Van Hoose and Kottler traced humanistic therapy and self-realization back to the Aristotelian ideas that every human act is based on motivation for good. They viewed self-realization theories as based in the belief that humans are "innately good and creative and able to make ethically right decisions[;] the self-realizationists encourage the maximization of human freedom, choice making, trust, and optimism" (p. 26). According to Van Hoose and Kottler, this translates into existential therapy guided by the belief that the primary role of the therapist is to assist clients in finding free expression, authenticity, and moral freedom.

Moral Development Theories

Van Hoose and Kottler (1988) saw the works of Piaget and Kohlberg as the cornerstones of understanding moral development. At the foundation of this psychological understanding of ethical development is a belief that humans are innately good. Therefore, children who are permitted to develop naturally will become

ethical adults. The psychological applications for moral development theories are numerous and stretch beyond the limits of this literature review.

Applied Ethics for the Practice of Professional Counseling

Significance of Professional Practice Ethics

> Our ethics acknowledge the great responsibilities inherent in the promise and process of our profession. They reflect the fact that if we do not fulfill these responsibilities with the greatest of care, people may be hurt. (Pope & Vasquez, 1991, p. 1)

Professional or applied ethics relates to a "particular discipline and only to the role-specific functions of the professional" (Tjeltveit, 1999, p. 20) and are consequently narrower in scope than philosophical or theoretical ethics. In applied ethics the professional is still required to deal with a wide range of issues, think theoretically and rigorously about ethical issues, and be prepared to provide a rationale for beliefs and decisions (Tjeltveit, 2000). Within professional life, right and wrong standards are guided and/or mandated by the laws related to professional conduct and license, professional codes of ethics, professional organizations, and discussions in professional publications (Corey et al. 2007; Remley & Herlihy, 2005; Welfel, 2006).

Pope and Vasquez (1991) put forth an applied ethics framework involving three basic ethical tasks for professional counselors. The first task involves acknowledging the worth of individuals with whom they work. The second task requires understanding the nature of professional relationships and the power of therapeutic

interventions. The third task involves counselors taking responsibility for their professional conduct.

Welfel (2006) delineated professional ethics as having four dimensions. The first dimension requires that counselors have an adequate knowledge and skill base in order to make effective clinical judgments and interventions. The second dimension addresses the professional responsibility to protect human dignity and promote client welfare. The third dimension concerns responsible use of the power inherent in the position. The fourth sets a standard of professional behavior that encourages public confidence in the counseling profession.

Van Hoose and Kottler (1988) encouraged therapists to consciously develop a personal approach to ethics and along with that encouragement offered a list of guidelines to aid the clinician in this development. Their guidelines cover such areas as (a) evaluating the origin and value of standard moral rules and principles; (b) contemplating personal payoffs for obeying or opposing moral rules and principles; (c) understanding who the ultimate benefactor(s) of a given moral behavior might be; (d) engaging in self-evaluation; and (e) wrestling with notions inherent in the transference of values to clients. Within these guidelines, Van Hoose and Kottler suggested exploring what, if any, situations would justify breaching accepted moral rules or principles of the profession, and they encouraged counselors to investigate possible situations that might motivate them to practice outside their understood competence areas.

Counselor Responsibility within the Clinical Relationship

Professional ethics are central to work and identity of counselors (Walden, Herlihy, & Ashton, 2003). Drane (1982) argued that ethics are central to the work of mental health professionals because "the context of psychotherapy is interlaced with ethical concerns, and the therapist cannot avoid being immersed in ethics" (p. 22). According to Van Hoose and Kottler (1988), any discussion of professional ethics must include an awareness of the therapeutic relationship as having a unique contract. The primary intent of the therapeutic contract is to promote client welfare and dignity (Gross & Robinson, 1987; Lakin, 1991; Stein, 1990; Van Hoose & Kottler; Wolman, 1982). Wolman declared two decades ago that violating the therapeutic contract is not an option for ethical counselors. According to Remley and Herlihy (2001), counselors who realize the extraordinary responsibilities intrinsic to the work of psychotherapy are serious about ethics.

Because the relationship contracted between counselors and client(s) is unique, "counselors have prima facie duties to persons who come to them for professional help" (Van Hoose & Paradise, 1979, p. 12). The idea of prima facie duties or obligations is referred to frequently in the literature on ethics and professional life. Beauchamp and Childress (2001) circumscribe prima facie duties or obligations as follows.

> A *prima facie* obligation must be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation. This type of obligation is always binding unless a competing moral obligation overrides or outweighs it in a particular circumstance. (p. 14)

Van Hoose and Kottler (1988) recognized making ethical determinations about human behavior necessitates having a theory about the nature of humankind, and thus, for Van Hoose and Kottler, counselors are ethical theorists. According to Drane (1982), there is no way to practice psychotherapy and avoid ethics, and applying ethics in therapeutic settings "requires tough-minded analyses of problems and high-level reflection on psychotherapeutic tradition and principles" (p. 20). Rosenbaum (1982) pointed out that although counselors regularly deal with ethical concerns, they do not need to be theologians or philosophers to be ethical practitioners. However, he insisted that professionals be prepared to act rigorously in confronting moral questions that are an integral part of clinical work. The process of confronting moral questions and making decisions about human behavior is sometimes referred to as ethical analysis (Frankena, 1963; Hill, 2004a).

Counselor Responsibility to Society: Privilege, Obligation, and Standard of Care

Society bestows upon individuals engaged in certain occupations the status of "professional." Counselors enjoy the privileges and responsibilities of membership in a profession (Remley & Herlihy, 2001; Stein, 1990; Welfel, 2006). Ethical obligation for professional counselors is not limited to client relationships. Professional counselors also have ethical responsibilities to the profession, professional colleagues, and society (Remley & Herlihy, 2001; Welfel). As early as 1979, Van Hoose and Paradise wrote about the social position inherent in the work of the mental health professional.

> Psychotherapy is now firmly rooted in modern society and is eloquently endorsed by people of authority and influence. The work of counselors and psychotherapists has become more than just a group of services or activities performed by members of the helping professions. Therapy is a major social force and is a primary influence in our beliefs, attitudes. (p. 48)

A standard of care must be maintained by the practicing mental health professional (Hill, 2004a; Mattison, 2000; Remley & Herlihy, 2001). According to Hill, "the standard of care is a socially negotiated set of norms by which the conduct of counselors is judged" (p. 138). According to Remley and Herlihy, the standard of care is technically a legal designation that measures counselor performance against that of other counselors with equal educational training in comparable situations.

Hill (2004a) suggested attention to standards of care provides a guide for counselors to manage professional tasks. When counselors are facing questionable situations that call for individualized and/or potentially challenging clinical judgment(s), Hill encouraged consultation with respected colleagues as a tangible way to gain insight into whether or not the standard of care has been met. Hill recognized there are tremendous pressures present in standard of care ethics, and balanced his encouragement for attention to standard of care with cautions that counselors not allow these pressures inordinately to skew clinical thinking and potentially compromise client welfare.

Disequilibrium of Power Necessitates Attention to Ethics

According to Pope and Vasquez (1991), the very nature of the profession and the disequilibrium of power inherent in psychotherapy compels counselors to attend to

ethics and ethical behavior. This obligation to ethical conduct is beyond that of the role(s) counselors have as private citizens. Because society has entrusted counselors with the charge to place their service to clients before their own self-interest, counselors are expected to demonstrate consistently ethical professional conduct (Kitchener, 2000; Pope & Vasquez; Stein, 1990).

According to Van Hoose and Paradise (1979), counselors have significant power in numerous areas of contemporary society. Van Hoose and Paradise suggested over two decades ago that the therapeutic community was becoming the new priesthood and contended that the very notion of a therapeutic priesthood opens up a window of insight into the power and influence held by mental health professionals. They further suggested that because counselors are often in the position of mediating between individuals and society and/or conveying the meaning of the social world to clients, they had come to occupy a position similar to that of priest.

The role of counselor, as ordained by society, places the professional in unequal and powerful relationships with clients who often come to therapy at vulnerable points in life (Carroll, 1997; Lakin, 1991). The work of mental health professionals places them in a "position of power and of doing something to others who are vulnerable" (Carroll, p. 163). This imbalance of power between client and therapist is commonly acknowledged within clinical settings (Carroll; Kitchener, 2000; Remley & Herlihy, 2005; Van Hoose & Paradise, 1979; Welfel, 2006). Failure on the part of the counselor to recognize the unequal distribution of power inherent in the therapeutic relationship precipitates ethical difficulties (Kitchener; Stein, 1990; Welfel).

Ethical Errors

Kitchener (1991) and Welfel (2006) pointed out that there are times when mental health practitioners do commit unethical acts. According to Kitchener, some of these situations can be attributed to a lack of complete knowledge or understanding of the ethical standards; a number of others may occur because of a failure to apply ethical knowledge to behavior. Welfel and others (Kitchener; 2000; Remley & Herlihy, 2005) indicated unethical conduct harms clients and sometimes result in individuals being in more serious internal and/or external turmoil than they were in prior to entering therapy. Additionally, unethical counselor conduct may cause clients, and/or others in their social systems, to become unwilling to engage in needed therapeutic services in the future (Welfel).

Welfel (2006) noted the number of ethical complaints filed annually is small in relation to the cumulative number of mental health professionals who hold membership in professional organizations. However, she argued it is impossible to know the frequency of violations, as many go unreported. Welfel observed underreporting may be because clients do not know the reporting process, do not choose to report, do not understand that the professional behavior was unethical, or colleagues choose to look the other way. Kitchener (1991) and Welfel both noted that unethical behavior is not restricted to novice clinicians. They observed that experienced psychiatrists, psychologists, social workers, mental-health counselors, educators, and professional leaders are often guilty of unethical conduct.

When ethical violations do get reported, professional organizations and licensure boards investigate each case, make a decision, and enact discipline. Organizational and/or board discipline may include suspension of membership and/or license depending on their jurisdiction. On occasions when the courts become involved, there may be lawsuits or criminal indictments (Remley & Herlihy, 2001; Welfel, 2002). Although lawsuits brought against mental health professionals are few, they are on the rise (Calfee, 1997).

Welfel (2002) acknowledged it is easy to have strong judgments concerning unethical behaviors, but because of the complexities involved in the practice of professional counseling she also indicated some grace may be in order. Leaders and practitioners in the field of counseling understand it is difficult, if not impossible, for even the best intentioned counselor to avoid the occasional minor ethical error (Van Hoose & Kottler, 1988; Welfel). Walden et al. (2003) interviewed former American Counseling Association (ACA) ethics committee chairs who reported that "as a result of their tenure as committee chair, they had become less judgmental concerning the ethical behaviors of others and increasingly aware of how easy it is to err" (p. 108).

Current Increase in Emphasis on Ethics

As the presence, power, and influence of the therapeutic community increases, so has awareness for increased attention to ethics and ethical concerns. Professional literature demonstrates a growing interest in and emphasis on ethical issues affecting the practice of mental health counseling (DePauw, 1986; Navin, 1995; Neukrug,

Lovell, & Parker, 1996; Stein, 1990). According to Hill (2004b), increasing demands of professional organizations, as well as accrediting bodies for academic programs, may drive this trend. The rise of managed care also precipitates new and increased ethical concerns (Tjeltveit, 2000). Increased litigation involving mental health professionals and the advancements of technology propel the profession to wrestle with ethical concerns (Stein).

Professional counselors have increasingly gained validation and influence during the past several decades (Remley & Herlihy, 2001). This is demonstrated by the fact that, according to the ACA web site (2006), professional counselors are now granted licensure in forty-eight states and the District of Columbia. Although increased professional esteem is a significant achievement, it comes with increased responsibility to the public. These extended responsibilities require greater attention to ethical concerns (Remley & Herlihy).

Professional Codes of Ethics

Purpose of the Codes

Codes of ethics are essential to professions, and although they do not address all possible ethical questions, they do furnish a basic framework and reference point for professional ethics and work (Drane, 1982; Van Hoose, 1986). According to Haas and Malouf (1995), ethics codes are a "combination of ethics, law, and etiquette" (p. 2). Codes of ethics published by most mental health professions address two levels of professional ethical conduct. There is the basic level that outlines fundamental

professional responsibilities and is thus considered *mandatory* ethics. Legal systems also establish and reinforce minimal standards for professions (Hill, 2004b; Welfel, 2006). In addition, most major codes, such as those of the American Counseling Association (ACA) (2005), the American Psychological Association (APA) (2002), the National Association of Social Workers (NASW) (1999), and the American Association of Marriage and Family Therapists (AAMFT) (2001), have traditionally contained additional standards that articulate the ideals therapists are challenged to aspire to and are known as *aspirational* ethics (Corey et al., 2007; Meara, Schmidt, & Day, 1996; Remley & Herlihy, 2001; Tjeltveit, 1999).

The most recently published *ACA Code of Ethics* (2005) has been reorganized from two sections clearly setting apart mandatory and aspirational standards to one unified set of standards. The earlier editions of the ACA code included two sections. The first was labeled "Code of Ethics," and according to Corey, Corey, and Callanan (1998), described aspirational ethics standards or the "ideals of the profession" (p. 5). The second section was labeled "Standards of Practice" and outlined the mandatory ethical standards for counselors. The 2005 ACA ethics code preamble states,

> Professional values are an important way of living out an ethical commitment. Values inform principles. Inherently held values that guide our behaviors or exceed prescribed behaviors are deeply ingrained in the counselor and developed out of personal dedication, rather than the mandatory requirement of an external organization. (p. 3)

Additionally, each section of the 2005 ethics code for counselors contains an introduction that "discusses what counselors should aspire to with regard to ethical

behaviors and responsibility" (p. 3). It appears that the 2005 ACA ethics code has integrated the previously separated ideas of mandatory and aspirational ethics.

The basic codes are generally conservative and reflect what the majority of the members of a profession can agree upon (Kitchener, 2000; Rosenbaum, 1982; Van Hoose & Kottler, 1988; Van Hoose & Paradise, 1979). Codes were originally developed to protect a profession from external regulation and are important because they unify the profession, promote public trust, and allow the profession to regulate itself and potentially errant members, thus protecting the public (Remley & Herlihy, 2001). When professionals face particularly troubling situations, the codes are sometimes able to help provide guidance and subsequent justification for professional action (Kitchener; Stein, 1990; Van Hoose & Paradise; Welfel, 2006).

Public trust is important to the establishment and growth of any profession and in turn society expects professions to self-regulate. There is an expectation that professional organizations, through codes and other means, will set minimum standards for competence and minimize incompetence. It is believed that as mental health professions establish standards and self-monitor according to their standards, the public will be reassured about quality of care (Remley & Herlihy, 2001; Stein, 1990; Van Hoose & Paradise, 1979).

At the beginning of the revised *ACE Code of Ethics* (2005) there is a section set aside to address the purpose, organization of the code, and some minimal guidance on dealing with ethical dilemmas. The five central purposes of the code are stated within this introductory section to the code. The purposes of the code are listed as (a)

clarification of the ethical responsibilities for members of ACA, (b) supporting the overall goals of the organization, (c) setting out the principles and consequent expected practices of members, (d) assisting members in discerning courses of action that will reflect the values of the profession, (e) serving as a standard for processing complaints against members.

Upon entering a profession, new members agree to abide by the codes of their chosen profession (Corey et al., 2007; Remley & Herlihy, 2001; Tjeltveit, 1999). However, as Herlihy and Corey (1997) pointed out, agreement to abide by the codes does not necessarily equate to being an ethical counselor, as codes only provide general standards. Although they acknowledged professional counselors will find guidance in the codes of ethics, Herlihy and Corey observed that for specific circumstances requiring complex decision-making, which necessitate guidance beyond that provided by the codes, counselors are ultimately responsible for their professional conduct. Herlihy and Corey noted that being an ethical counselor necessitates an unrelenting willingness to examine ethical functioning, struggle with uncertainties encountered in professional life, and attend to the ongoing task of keeping up to date in an ever-changing world.

According to Herlihy and Corey (1997), virtuous, ethically conscious counselors strive for excellence in practicing aspirational ethics. Additionally, Herlihy and Corey pointed out professional excellence requires counselors to be more concerned about keeping current, examining their clinical life, and doing what is right for the client

rather than simply following the letter of the law. Corey et al. (2007) encouraged counselors to understand and practice both mandatory and aspirational ethics.

Limits of the code

A number of authors (Corey et al., 2007; Drane, 1982; Kitchener, 1984a, 2000; Remley & Herlihy, 2005; Stein, 1990; Van Hoose & Paradise, 1979; Welfel, 2006) argued there are some natural limits in the application of codes of professional ethics and in exercising the ideal of professional self-regulation. First, codes are intended as a basic framework and reference point (Drane, Van Hoose, 1986) and are not designed for the specifics of the many troublesome situations professional counselors can encounter in clinical practice. Consequently, they do not work well as a reference for those specific, and often complicated, situations. A second difficulty with the codes is that they may, at times, conflict with specific laws and their application. Third, although codes are revised regularly in an attempt to address the broad scope of professional practice, situations emerge in the course of clinical life for which the codes are silent. Fourth, the codes do not list their underlying rationale for purposes of application and consequently counselors must look elsewhere for the education necessary to apply codes ethically. Finally, when encountering particularly complex situations, counselors may experience an internal inconsistency in the codes.

The ACA Code of Ethics and Standards of Practice

The predominant measure of ethical behavior for counselors is the code of ethics put forth by the professional organization(s) to which they belong (Remley & Herlihy, 2005; Welfel, 2006). In addition to being answerable to state licensing boards, licensed professional counselors are held accountable to the current code of ethics published by ACA in 2005 (Remley & Herlihy). Some licensed professional counselors hold memberships in more than one professional organization. Counselors may also hold specialty credentials or belong to branches of professional associations that are consistent with their particular interests and/or specialized training. Each of these organizations, branches and credentialing bodies may have codes of ethics to which counselors can refer in situations of ethical quandary (Welfel, 2006).

The ACA code of ethics has its roots in what was first known as the American Personnel and Guidance Association (APGA), and then later as the American Association for Counseling and Development (AACD), and has now become the American Counseling Association. The association's first code of ethics was put forth for review by the membership of what was then the APGA in 1959 and was officially adopted in 1961. The code was revised in 1974 and again approximately every 7 years. Revisions are intended to reflect changes in client presenting problems, counselor practice, and American culture (Remley & Herlihy, 2001; Walden et al., 2003). The latest revision of the ACA code was presented in 2005 and is available on the ACA website.

The ACA Ethics Committee was established to give direction to educating members in matters of ethics and to adjudicate reports of ethical violations among the membership. Walden et al. (2003) reported that plans were announced in 1998 to form a separate adjudication panel and thus split the committee functions. Some of the efforts the committee has made to educate members concerning the code of ethics have included publication of several editions of the *Ethical Standards Casebook* (Callis, 1976; Callis, Pope, & DePauw, 1982; Herlihy & Corey, 1996; Herlihy & Golden, 1990).

Human Dignity, Client Welfare, and Avoiding Harm

Promoting client welfare, protecting client dignity, and avoiding or minimizing potential harm are the cornerstones of ethical behavior (Lakin, 1991; Gross & Robinson, 1987; Stein, 1990; Wolman, 1982). Each of the codes of ethics to which the participants in this study are responsible declares promoting client welfare and protecting human dignity as primary. Five codes of ethics directly guide the professional counselors who participated in this study. Each of the five ethical codes clearly asserts that the clinical work of professional counselors is to be grounded in respect for client dignity and welfare.

Two codes apply to all of the participants in this study. The *Code of Ethics* (2005), put forth by the ACA, sets the overarching standard for ethical conduct to which all professional counselors are expected to adhere (Remley, & Herlihy, 2005; Welfel, 2006). The American Mental Health Counselors Association (AMHCA) is a

division of ACA with an additional set of ethical standards that are applicable to each of the counselors who participated in this study.

Three additional codes, which are pertinent to this study, apply to select participants. One counselor in the study is, by training and practice, a career counselor, and is responsible to practice in accordance with standards of the National Career Development Association (NCDA). One participant self-identified as a rehabilitation counselor and is expected to adhere to standards of the Commission on Rehabilitation Counselor Certification (CRCC). The NCDA and the CRCC are divisions of ACA, and have established ethical standards specific to counselors practicing within their particular specialties. The National Board of Certified Counselors (NBCC) is an accrediting body for professional counselors and has developed an additional set of ethical guidelines for its members. Six participants reported holding the National Certified Counselor (NCC) credential, and are required to adhere to the NBCC code of ethics.

The ACA (2005) and AMHCA codes (2000) address client dignity and welfare. The *ACA Code of Ethics* (2005) states, "the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients" (Section A.1.a). The first principle of the *AMHCA Code of Ethics* (2000) includes consideration for the welfare of the consumer within the first principle. Section A. 1 of the AMCHA code states, "the primary responsibility of the mental health counselor is to respect the dignity and integrity of the client. Client growth and development are encouraged in ways that foster the client's interest and promote welfare."

Codes specific to career, rehabilitation and NBCC certification are equally clear about the priority of client dignity and welfare. The NCDA *Ethical Standards,* revised in 2003, addresses the counseling relationship and states, "the primary obligation of NCDA members is to respect the integrity and promote the welfare of the client" (Section B.1). *The Code of Professional Ethics for Rehabilitation Counselors* (2002) addresses client dignity and welfare in its preamble that begins: "Rehabilitation counselors are committed to facilitating the personal, social, and economic independence of individuals with disabilities." Addressing the counseling relationship, the NBCC *Code of Ethics*, approved in 1982 and most recently amended in 2005, states, "the primary obligation of certified counselors is to respect the integrity and promote the welfare of clients, whether they are assisted individually, in family units, or in group counseling" (Section B.1).

Throughout all mental-health professions, the idea of human dignity and welfare is evident as integral to ethical behavior. The ethical codes referenced in this literature review extend beyond those to which the licensed counselors who participated in the study are directly accountable. The APA, NASW, and AAMFT codes provide additional insight into the standard of care expected of all mental health professionals and also are referenced in this literature review. Each of these codes also calls for their membership to attend to issues of client dignity and welfare.

The *APA Ethical Principles of Psychologists and Code of Conduct* (2002) preamble states the code "has as its goal the welfare and protection of individuals and groups with whom the psychologists work." The APA *Ethical Principles* deal with

both human dignity and worth. Principle E, entitled "Respect for People's Rights and Dignity," begins, "Psychologists respect the dignity and worth of all people."

Professional organizations to which social workers and those who identify themselves primarily as marriage and family therapists belong have focused on concerns of client dignity and welfare. According to the *Code of Ethics of the National Association of Social Workers* (1999) preamble, "the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty." The first principle of the AAMFT *Code of Ethics* (2001), which addresses therapist responsibilities to clients, declares, "marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately."

A review of these codes of ethics clearly supports the idea that mental-health professions are fundamentally committed to respecting human dignity and promoting client welfare. Although the standards of the professions are intended to promote client welfare, mental health professionals sometimes find it difficult to sort out confusing and complex legal and ethical boundaries in the midst of trying to do what is most helpful for clients (Gross & Robinson, 1987). The goal of ethical study, research and questioning is to assist professionals in fulfilling these primary responsibilities (DePauw, 1986).

ETHICAL DECISION MAKING

Overview and Fundamentals

Significance

Ethical decision making is part of the everyday work of mental health professionals (Stein, 1990; Van Hoose & Kottler, 1988; Van Hoose & Paradise, 1979; Walden et al. 2003). According to Van Hoose and Paradise, "nearly every intervention, indeed, almost everything said and done, has potential ethical ramifications" (p. 56) for counselors. Stein pointed out that the everyday ethical struggles of clinical work are becoming increasingly more complex.

Several authors have called attention to the need for the mental health professions to think more thoroughly about the ethical decision-making process (Cottone & Claus, 2000; Kitchener, 1984a, 2000; Tymchuk et al., 1982). Two decades ago, Kitchener observed, "we are better at identifying the ethical issues that face us than we are at thinking through how we ought to resolve them" (p. 15, Kitchener, 1984a). In 1982 Tymchuk et al. published research results regarding ethics training and concluded the professions needed to "attend more closely to decision-making processes and develop decision-making standards that can be applied to situations as they arise" (p. 420). Kitchener voiced her concerns on this matter again in 2000 when she argued for a "deeper understanding of ethical decision making" (p. 5). In 2000, Cottone & Claus observed that there is still a general "lack of in-depth discussion of ethical decision-making processes in the literature" (p. 275).

Gross and Robinson (1987) and others (Remley & Herlihy, 2001; Kitchener; 2000) indicated that although the primary standard for resolving ethical dilemmas would appear to be codes of ethics, ethical codes are often not definitive enough to be used without accompanying resources. Ethical decision making involves developing ethical sensitivity (Rest, 1984; Stein, 1990), understanding moral principles as agreed upon by the profession (Beauchamp & Childress, 2001; Drane, 1982; Kitchener, 1984b, 2000; Van Hoose, 1986; Welfel, 2006), enacting virtuous character (Cohen & Cohen, 1999), realizing the relationship between virtuous character and moral principles (Meara, et al., 1996; Welfel, 2002), and having an awareness of the influence of personal values on the therapeutic and decision-making processes (Hill, Glaser & Harden, 1995; Remley & Herlihy).

Ethical Sensitivity and Ethical Reasoning

Ethical sensitivity, or the ability to view situations through an ethical lens and consequently to readily recognize ethical difficulties, is obtained through intentional conscious awareness and training in making ethically pertinent inquiry (Rest, 1984, 1994; Stein, 1990; Welfel, 2006). Rest and others (Kitchener, 1984b, 2000; Stein; Welfel) indicated the ethical decision-making process begins with ethical sensitivity. They argued that ethical issues are always present but to the untrained or inattentive observer they are not always apparent.

Welfel (2006) contended that effective counselors have developed an ethical sensitivity that informs their ethical behavior. Corey et al. (2007) cautioned counselors

to stay vigilant in the examination of the changing dimensions of ethical issues throughout the course of their professional careers. According to Biggs and Blocker (1987), attaining an effective level of ethical sensitivity is a developmental process.

> Each new client, each new problem or tangled set of relationships that we encounter in clinical practice should move us toward greater and greater capacities for empathetic understanding. As we travel this thorny path of professional development, we become more and more sensitive to ethical issues and concerns. (p. 108)

The most basic ethical decision-making issues range from considering whether or not to take a client on, to when and what to say in routine interventions (Lakin, 1991). Some of these basic ethical decisions are made on the conscious level, but others are made automatically, and are not part of an intentional and/or conscious process (Welfel, 2006). Two differing levels of ethical reasoning are discussed in mental health literature. The more automatic or intuitive level is a spontaneous reaction to situations that may or may not be conscious. The second level of ethical reasoning, which Kitchener (1984b, 2000) called the critical-evaluative level, is the more conscious analysis based on professional standards and scholarship. This second level calls for a logical rationale for selected actions and is seen as necessary for effective professional performance (Rest, 1984; Kitchener; Van Hoose, 1986; Welfel, 2006). Welfel (1998) summarized this professional requirement for the critical-evaluative level of reasoning.

> Needless to say, not all people have . . . admirable moral intuitions . . . . Consequently, our profession demands that we be able to *justify* the ethical decisions according to ethical principles we make and show how they fit with accepted standards for moral behavior. (p. 23)

Welfel (2002) and Rest (1984, 1994) both acknowledged there are times when individuals who possess ethical sensitivity choose the less ethical or responsible course of action. Rest attributed this to a lack of moral courage. Welfel indicated that because counselors generally want to view themselves as good, they may experience internal discomfort when choosing an unethical course of action. According to Welfel, counselors sometimes handle this internal discomfort or conflict by redefining the problem rather than wrestling with the difficulties and/or choosing what is sometimes a tough solution.

Ethical Dilemmas

Straightforward or simple ethical decisions are a part of everyday experience for the professional counselor. Haas and Malouf (1995) reported that counselors take in an "enormous amount of information in the context of underlying 'operating principles'" (p. 7) on a daily basis and regularly make ethical choices almost without conscious thought. Whereas some situations are uncomplicated, and draw only on ordinary moral understandings developed in everyday life, the mental health professional also faces increasingly complex ethical difficulties (Kitchener, 1984b, 2000; Haas & Malouf, 1995, Welfel, 2002).

Complex situations which have no obvious or simple answer are known as ethical dilemmas (Kitchener, 1984b; Remley & Herlihy, 2001; Welfel, 2002). Counselors regularly confront a range of ethical dilemmas (May & Sowa, 1992; Neukrug et al., 1996; Remley & Herlihy; Welfel & Lipsitz, 1983). Carroll (1997)

indicated this may be because the very nature of the work in which counselors engage creates opportunity for encountering ethical dilemmas. Burkemper (2002) summarized the ethical dilemma as a situation that "presents the therapist with two or more good reasons to make two or more reasonable decisions" (p. 203). Each of these complex decision-making processes may have highly individualized outcomes, as various counselors will reach different, yet equally acceptable solutions when confronting similar dilemmas (Corey et al., 2007; Walden et al., 2003; Welfel, 2002).

Ethical dilemmas require the professional to become involved in an extended and complex decision-making process (Corey, Corey, and Callanan, 2003; Remley & Herlihy, 2001; Welfel, 2002). It is generally agreed ethical dilemmas involve several common factors (Hill et al., 1995; Kitchener, 1984b, 2000; Rollins, 1997; Van Hoose, 1986): (a) The dilemma presents circumstances and calls for considerations for which there is no clearly charted course of action or guidance in the codes or the literature; (b) There is more than one possible solution and each of possible solutions, although all potentially valid, may flow from contradictory ethical reasoning; (c) Simple reference and adherence to the codes cannot solve the difficulty because in these complex and troubling situations the codes often are silent and/or present contradictions.

Moral Principles: Guidelines for Mental Health Professionals

According to Beauchamp and Childress (2001), moral principles provide "a moral framework for identifying and reflecting on moral problems" (p. 15). They are

seen as being *prima facie* valid, and therefore must be referenced when confronting an ethical concern (Kitchener, 2000; Remley & Herlihy). The primary principles relevant to the work of professional counselors are not necessarily of equal weight in all circumstances (Kitchener; Remley & Herlihy; Welfel, 2002). There are some agreed-upon situations in which a given principle takes precedence. Frequently there are situations in which basing a decision on one principle will, by nature of the case, create a direct or indirect violation of another principle. There is no set rule on what course of action counselors should take when a conflict in principles is encountered (Beauchamp & Childress, 2001; Kitchener, 1984b, 2000).

As far back as 1981, Hare stated that for most professions "the prima facie principles applying especially to their members have been to some extent made articulate, if not in the codes of conduct, at least in the consistent practice of disciplinary bodies" (pp. 35-36). A number of authors (Beauchamp & Childress, 2001; Corey et al., 2007; Forester-Miller & Davis, 1996; Hansen & Goldberg, 1999; Jordan & Meara, 1990; Kitchener, 1984b, 2000; Meara et al., 1996; Remley & Herlihy, 2001; Stadler, 1986; Van Hoose, 1986; Welfel, 2006; Welfel & Kitchener; 1992) reference the four basic moral principles of autonomy, nonmaleficence, beneficence, and justice. In her 1984 seminal article Kitchener added fidelity to this list. A number of other authors (Corey et al., 1998, 2003, 2007; Forester-Miller & Davis; Hansen & Goldberg; Remley & Herlihy, 2001, 2005; Van Hoose; Welfel; Welfel & Kitchener) also include this fifth principle to their list of basic moral principles to be considered in ethical decision making. Since 1984 these five moral principles have been considered the

basic moral principles for ethical decision making in the mental health professions (Meara et al., 1996). In 1996 Meara et al. added veracity as the sixth moral principle. Only Corey et al. (1998, 2003, 2007) and Remley and Herlihy (2001, 2005) were found to have subsequently added the sixth moral principle of veracity to their discussions of moral principles. Other authors (Cohen & Cohen, 1999; Garcia, Cartwright, Winston, & Borzuchowska, 2003; Haas & Malouf, 1995) have generated lists that build on the basic principles but add various other principles.

The following brief overview of the basic moral principles used for ethical decision making by mental health professionals is drawn from general descriptions found in ethics literature (Beauchamp & Childress, 2001; Cohen & Cohen, 1999; Corey et al., 2007; Forester-Miller & Davis, 1996; Hansen & Goldberg, 1999; Jordan & Meara, 1990; Kitchener, 1984b, 2000; Meara et al., 1996; Remley & Herlihy, 2001; Stadler, 1986; Van Hoose, 1986; Welfel, 2006; Welfel & Kitchener, 1992). A comprehensive discussion on ethical decision making and moral principles is found in the Beauchamp and Childress texts (1979, 1983, 1989, 1994, 2001). These moral principles provide the foundational rationale for codes of ethics (Kitchener, 2000; Welfel).

Autonomy

Autonomy is about respect for choice, freedom, and dignity. Autonomy entails individual responsibility for behavior. Freedom implies a reciprocal respect in relationship. The basic limit of freedom is that one individual's freedom cannot

interfere with the freedom of others. Counselors are to encourage self-determination and discourage dependency. According to Stein (1990), counselors have a responsibility to provide clients with information that leads to an educated decision. Counselors "must recognize that adults have a right to determine their own fate, that they are capable of making rational choices" (Stein, p. 27).

Counselors are charged to work in a manner respecting the choices of their clients and to interfere with these choices only under "special circumstances." An example of "special circumstances" is the need for breach of confidentiality in "duty to warn" situations. A second consideration informing the limits of autonomy is client competence. Autonomy implies the client is able to make rationale choices.

Nonmaleficence

This principle, commonly known as "above all do no harm," is rooted in medical practice ethics, and can be traced to the ancient Greek Hippocratic oath. Nonmaleficence is fundamental to a profession dedicated to promoting the welfare of those they serve. To engage in harmful activities would be a direct contradiction to the fundamentals of the profession. The counselor is charged to avoid preventable risks and refrain from "actions that risk hurting clients, even inadvertently" (Remley & Herlihy, 2001). Nonmaleficence requires thinking about risk factors involved in using innovative techniques without formal training (Welfel, 2006) or when research does not confirm the benefits of the techniques (Kitchener, 1984b). Welfel suggested that when counselors can foresee potential harm, it is preferable to do nothing rather than

risk causing harm. Meara et al. (1996) suggested incompetence is a major factor in counselors breaching the principle of nonmaleficence.

Beneficence

Beneficence is generally understood to encompass the profession's central commitment to "do good." Society and the individual who come for mental health services expect to benefit from services. Counselors are mandated to be intentional about promoting the mental health, well-being, and positive growth of those they serve (ACA, 2005).

There is a direct connection between this particular principle and counselor competence (Kitchener, 1984b; Van Hoose, 1986; Welfel, 2006). It is the concept of beneficence that underlies the standards in the codes requiring counselors to work within the boundaries of their competence. Incompetent professional work is clearly unethical, fails the client, and undermines public trust in the profession (Meara et al., 1996; Remley & Herlihy, 2001; Welfel).

According to Kitchener (2000), there are times when the principle of autonomy may conflict with the principles of nonmaleficence and/or beneficence. Kitchener contended that in such situations doing the greatest good for the many should not be seen as an automatic reason to sacrifice autonomy of the individual. Additionally, Kitchener argued counselors must balance the potential for good against possible harm.

Justice

Justice is the principle that addresses the issues of just and fair treatment for all individuals. The principle of justice is based on the "assumption that people are equals" (Kitchener, 1984b, p. 50). Counselors are to treat all clients equally and without prejudice or discrimination. In situations where there is a need for unequal treatment (i.e., fee difference), the counselor must be able to provide a rationale demonstrating that there are in fact differences meriting differing treatment(s) (Kitchener, 1984b). Justice requires counselors to balance the civil liberties and welfare of the individual in treatment against the civil liberties and welfare of others (Kitchener, 2000).

Fidelity

Fidelity is the principle that deals with faithfulness to commitments, trustworthiness, loyalty, honesty, and promise keeping. Deceit and exploitation are in direct contradiction to the therapeutic contract. Confidentiality and informed consent are professional commitments central to fidelity. According to Meara et al. (1996), the natural dynamics within therapeutic relationships (e.g. inherent power differential) ethically obligate counselors to practice within the mandates of fidelity. This principle also has implications regarding commitment to colleagues, employers, and the profession (Welfel, 2006).

Welfel (2006) pointed out that the emphasis of fidelity is on "avoiding deception and . . . not on brutal honesty" (p. 36). According to Welfel, there are times when it is

inappropriate to share reactions to a client's presentation or points of view. She recommended honesty be mixed with wisdom and encouraged counselors give consideration to possible effects on the client, the therapeutic process, and the therapeutic alliance when sharing information and reactions.

Veracity

Veracity deals with truthfulness. Corey et al. (2007), Meara et al. (1996), and Remley and Herlihy (2001) set the truthfulness portion of fidelity apart from loyalty and commitment to form a separate principle. According to Corey et al., Meara et al., and Remley and Herlihy, counselors are compelled to be honest with those they serve. Efforts to "insure that clients understand the implications of diagnosis, the intended use of tests and reports, fee, and billing arrangements" (Corey et al., 2003, p. 17) have been included within the principle of veracity. The formalization of informed consent is a clear example of truthfulness between counselor and client.

Counselor Virtue and Values Impact Decision Making

The character and integrity of the individual applying ethical codes and agreed-upon moral principles is core to the ethical decision-making process (Cohen & Cohen, 1999; Meara et al., 1996). According to Van Hoose and Kottler (1988), ethical decisions develop out of the counselor's "feelings, beliefs, prejudices, and experiences" (p. 170). It is this notion, that individual orientation influences ethical actions, which necessitates understanding the factors of counselor virtue and values in

relation to ethical decision-making (Corey et al. 2003; Meara et al.; Remley & Herlihy, 2005; Welfel, 2006).

Ethical codes and the moral principles selected by the profession provide guidance and can assist in ordering thoughts and rationale. However, according to Remley and Herlihy (2001), each counselor is ultimately responsible for his or her own professional conduct. Corey et al. (2003) encouraged counselors to develop her or his own ethical positions but cautioned the practitioner not to make ethical decisions based solely on personal feelings or intuition. Herlihy and Corey (1997) maintained that counselors must be willing to wrestle with the inevitable uncertainties emerging in the course of clinical work, while consistently engaging in an intentional process of self-examination and persistently attending to the ongoing task of keeping up to date in an ever-changing world.

Van Hoose and Kottler (1988) encouraged counselors to engage in a vigorous reasoning process rather than blindly following the codes in a simplistic fashion. They pointed out that many of history's greatest tragedies have been a result of unreasoned compliance with authority. The models of ethical conduct suggested by theorists, law, society, or professional organizations may not always be completely compatible with the counselor's own system of morality (Van Hoose & Paradise, 1979). Browne (1973) justified the necessity for a well-defined, personally responsible, yet individualized moral decision-making process.

> When you decide to take matters into your own hands, someone may ask you . . . Who are you to decide for yourself in the face of society and centuries of moral teachings? The answer is simple: You are you, the person who will live with the

> consequences of what you do . . . . You have to be the one to decide . . . . You have to know. (Browne, p. 59)

Given the influence of personal character and values and the inevitability for individual responsibility, counselors may wonder how they can determine whether or not their actions are ethical (Remley & Herlihy, 2001). Van Hoose and Paradise (1979) suggested four components by which the therapist can gauge ethically responsible behavior. The first is maintenance of personal and professional integrity. The second is acting in the best interest of the client. The third is acting without malevolence or desire for personal gain. The fourth is being able to offer a rationale for decisions consistent with current professional thinking. Van Hoose and Paradise suggested that when counselors have satisfied these four measures of ethical behavior, they have reasonable grounds to believe they acted ethically.

Virtue Ethics

> Virtue ethics looks at moral action within the context of moral agency. As defined by Aristotle, the ancient Greek philosopher, moral virtues are states of character concerned with rational control and direction of emotions. Moreover, such states of character are, according to Aristotle, habits acquired from repeatedly performing virtuous actions. (Cohen & Cohen, 1999, p.19)

Several voices (Cohen & Cohen, 1999; Jordan & Meara, 1990; Meara et al., 1996) challenged the mental health professions to give more consideration to virtue ethics in understanding ethical decision making. Pojman (1995) indicated virtuous character is of critical importance "for if and only if we have very good people can we ensure habitual right action" (p. 12). Jordan and Meara pointed out that professional judgment and ethical decisions emerge out of character. Beauchamp and Childress

(2001) stated that "persons of high moral character acquire a reservoir of good will" (p. 31). According to Meara et al., individuals who have generated "good will" through perceived high moral character will receive a greater portion of grace from the profession during difficult times.

Although there is agreement concerning virtuous character as fundamental to the ethical decision-making process, it has also been argued that in dealing with the complexity of ethical dilemmas, virtue needs to be accompanied by a clear set of professional moral principles and well-developed reasoning skills (Corey et al., 2007; Jordan & Meara, 1990; Kitchener, 1984b, 2000; Miller, 1991; Rest, 1984; Stadler, 1986). Within the discussion of virtue and principle ethics Jordan and Meara distinguished the two as follows:

> Typically, principles are used to facilitate the selection of socially and historically acceptable answers to the question "What shall I do?" when confronted by ethical dilemmas. Virtue ethics, however, generally focus on the question "Who shall I be? (p. 107)

For the counseling profession, the core question in virtue ethics centers around what kind of character is essential for being a counselor (Remley & Herlihy, 2001). There is some consensus in counseling literature about the particular virtues or character qualities desirable for the professional counselor. The five most agreed-upon virtues can be grouped as prudence or practical wisdom, integrity, respectfulness or being tolerant, trustworthiness or conscientiousness, and compassion or care (Corey et al., 2007; Kitchener, 2000; Remley & Herlihy). Beauchamp and Childless (2001), as well as Kitchener, offered extensive discussions on each of the virtues.

Prudence. The virtue of prudence is demonstrated through sound ethical reasoning that translates into solid yet adaptable applications in clinical situations (Kitchener, 2000). Prudence or practical wisdom comes from the Greek word *phronesis* (Kitchener). The translation of *phronesis* denotes a practical wisdom that includes the ability "to discern modes of action with a view to their results" (Vine, 1966, p. 221). Meara et al. (1996) indicated that prudence is closely linked to professional competence.

Remley and Herlihy (2001) followed the lead of Beauchamp and Childress (1994, 2001) in choosing to use the term "discernment" for this virtue. Remley and Herlihy included, in the notion of discernment, the ideas of ethical sensitivity, knowledge of applicable ethical principles, the ability to tolerate uncertainty, and insightful perspective on action and potential consequences. Beauchamp and Childress have emphasized the sense of judgment or the ability to understand and judge a situation without bending to external pressures with the virtue of discernment or prudence. Meara et al. (1996) suggested this virtue includes

> appropriate restraint or caution, deliberate reflection upon which moral action to take, and understanding of the long-range consequences of the choices made, acting with due regard for one's vision or what is morally good, and a knowledge of how present circumstances relate to that good or goal. (p. 39)

Integrity. Integrity involves actions that emerge from a belief in what is right (Remley & Herlihy, 2001). A description of integrity is often easier to be found in what it is not rather than what it is (Kitchener, 2000). Those who cannot be counted on to keep their word or uphold moral values, as well as those who act in bad faith or deceive themselves about motive are said to lack integrity (Kitchener; Beauchamp &

Childress, 2001). To be lacking in integrity would be equal to lacking in competence (Meara et al., 1996). Integrity requires that one's commitment to doing what is morally best remains consistent and unwavering even under pressure or adversity. For counselors, what is morally best is defined by rules and principles set by the profession (Kitchener). Meara et al. and Beauchamp and Childress pointed out that there is a fine line between integrity and rigidity. They suggested there is some room for reasoned compromise, such as when principles conflict with particular cultural groups in specific situations.

Respectfulness. The virtue of respectfulness is a willingness to extend to others consideration for their concerns, wants, needs, and perspectives. Because actions taken by counselors affect client well-being, this character trait is considered central to counselor moral fiber. A lack of respectfulness may manifest as racism, sexism, and/or other forms of intolerance (Kitchener, 2000; Meara et al., 1996). This virtue is sometimes termed "self-awareness" (Meara, et al.; Remley & Herlihy, 2001). Self-awareness is about counselors knowing their own beliefs, persuasions, and biases. According to Remley and Herlihy, self-knowledge assists the counselor in understanding how his or her attitudes and interactions may affect clients.

Trustworthiness. Trustworthiness is found in virtuous agents who are known to have solid character. Counselors who demonstrate solid character generate confidence in their capacity to be trusted by society, colleagues, and clients. Cohen and Cohen (1999) identified trustworthy counselors as having "habits of honesty, candor, competence/benevolence, diligence, loyalty, discretion, and fairness" (p. 73).

According to Beauchamp and Childress (2001), the trustworthy counselor is a conscientious professional who is "motivated to do what is right because it is right, has tried with due diligence to determine what is right, intends to do what is right, and exerts an appropriate level of effort to do so" (p. 37). Kitchener (2000) argued vulnerable clients must be able to trust counselors to carry out their role in a consistent and professional manner.

Compassion. The virtue of compassion or care, according to Beauchamp and Childress (2001), is "a trait that combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness, and discomfort at another's misfortune or suffering" (p. 32). Remley and Herlihy (2001) labeled this virtue as "acceptance of emotion" (p. 8) and argued virtuous counselors understand emotion has a role in ethical decision making. Kitchener (2000) contended compassion or care ethics require counselors to balance virtue and principle. Within the idea of care ethics is a belief that counselors need to be able to care for others, without neglecting care of self. Compassion requires integrating interventions based on ethical principles with compassionate understanding of situational factors without neglecting principles. Beauchamp and Childress pointed out that compassion differs from integrity, because compassion is "other-focused" and integrity is "self-focused."

The Relationship Between Principle and Virtue Ethics

> Principle ethics can be described as a set of *prima facie* obligations one considers when confronted with an ethical dilemma. Virtue ethics focuses on

> character traits and nonobligatory ideals that facilitate the development of ethical individuals. (Meara, et al., 1996, p. 4)

Meara, et al. (1996) argued for more in-depth discussion concerning virtue ethics in regard to ethical decision making and maintained conversations that include a "thorough understanding and integration of virtue ethics can result in better ethical decisions" (p. 5). For Meara et al. professional ethics encompass more than moral actions or *obligations* because, according to Meara et al., moral actions emerge from moral or virtuous character that reaches for the *ideal.* The integration of principle ethics and virtue ethics is a balancing of two intrinsically valuable components in the ethical decision-making process. Consequently, for Meara et al., virtue ethics provides a significant, essential, and complementary approach to principle ethics.

Beauchamp and Childress (2001) contended motivation for moral action is linked to character or virtue. Kitchener (2000) observed that every moral "principle has a corresponding character trait that predisposes a person to act on that principle" (p. 46). However, Kitchener also pointed out this does not work in reverse, as all character traits do not have comparable moral principles. Beauchamp and Childress related respectfulness to autonomy, nonmaleficence to nonmalevolence, beneficence to benevolence, justice to fairness, fidelity to faithfulness, and veracity to truthfulness or trustworthiness.

Kitchener (2000) acknowledged understanding the relationship between ethical decision making and good character is not easy. However, she contended prudence, integrity, respectfulness, trustworthiness, and compassion are all foundational to being sensitive to the moral principles of autonomy, beneficence, nonmaleficence,

beneficence, justice and fidelity. Kitchener also maintained that the listed character traits are foundational to moral motivation and courage when facing multifaceted ethical dilemmas.

Values

There was a time when psychotherapy was seen as value-free; however, it is now generally recognized as a value-laden process (Corey et al., 2003; Tjeltveit, 1999). Miller (1983) put forth the following questions, which emerge from the discipline of ethics, to demonstrate the value-laden foundations of the counseling process.

> What are the principles of right or good conduct, and how are they established or justified? What are the proper goals for a life and are they universally applicable or individualized? Are there moral obligations that supersede individual needs or desires? What is appropriate behavior? (p. 214)

Miller contended the answers to these questions determine the accepted norms for defining mental health that in turn impacts counselor interventions, and procedures involved in maintaining ethical practice (e.g. fee setting and decisions for involuntary commitment).

Van Hoose and Paradise (1979) defined values as "attitudes, convictions, wishes, and beliefs about how things ought to be" (p. 18). Several writers (Bergin, 1985; Corey et al. 2007; Remley & Herlihy, 2001; Tjeltveit, 1999) have contended counselors are not value-neutral beings. According to Corey et al., Brace (1997), and Tjeltveit there are times when counselor values influence the therapeutic process. Stadler (1986) emphasized that, in the course of clinical work, counselors are not "neutral, unbiased observers of the lives that pass before [them]" (p. 3). Stein (1990)

and others (Corey et al.; Lakin, 1988; Remley & Herlihy; Tjeltveit) insisted that it is critical counselors work to understand their own values precisely because values are an integral part of the therapeutic process.

When counselors face difficult ethical dilemmas they are often encouraged to attend to their own values (Kitchener, 1984a, 2000; Remley & Herlihy, 2001). According to Kitchener (1984a), values can be defined as "something . . . that is considered desirable" (p. 17) and pointed out that professional values are not arbitrary. As members of the counseling profession, counselors agree to professional standards that delineate some actions and values as desirable and others as undesirable (Kitchener, 1984a, 2000; Stein, 1990).

The ACA (2005) ethics code states, "counselors are aware of their own values, attitudes, belies, and behaviors and how these apply in a diverse society, and avoid imposing their values on clients" (Section A.4.b). London (1984) and Stadler (1986) argued counselors are moral agents because their work, which flows out of their own personal moral system, influences the decisions of their clients. Stadler asserted that as moral agents counselors must be careful to respect client autonomy and work to minimize the influence of counselor values on client choices. According to Corey et al. (2007), counselors are expected to realize clients will be influenced by counselor values, and therefore must attend closely to situations where client and counselor values conflict. Corey et al. suggested consultation and/or referral as steps that may be necessary when values conflicts arise.

System Influence on Ethical Decision Making

Several authors (Cottone & Tarvydas, 2003; Koocher & Keith-Spiegel, 1998; Tarvydas & Cottone, 1991; Welfel, 2006) have written about the relationship between organizational or institutional dynamics and the ethical decision-making process. According to Welfel, counselors working in settings that create a culture of high ethical standards will be more likely to experience positive reinforcement and support in situations requiring complex ethical decision making and less likely to encounter resistance to difficult, yet necessary, ethical choices. Koocher and Keith-Spiegel (1998) suggested the "impact of ethical pressures within the workplace may produce responses that range from subtle erosion of professional values to overwhelming emotional distress" (p. 340). Tarvydas and Cottone highlighted the need for attention to the interplay between system dynamics and ethical decision making in the following statement.

> Ultimately, recognition of multiple and discrete levels of social influence on ethical decision making is important to a profession where practice is so firmly embedded in a sociological and economic system. (p. 13)

A number of authors (Cottone & Tarvydas, 2003; Hansen & Goldberg, 1999; Koocher & Keith-Spiegel, 1998) have pointed out that there may be times when employer policies may conflict with a counselor's understanding of ethical conduct around issues such as information sharing and case management. Governmental agencies, military settings, educational institutions, hospitals and other medical facilities, correctional facilities, and private practice are settings where counselors may find themselves in ethical conflict with their work culture (Koocher & Keith-Spiegel).

Koocher and Keith-Spiegel reported that in some instances counselors "may be asked or told to behave in an ethically inappropriate manner as a function of the employing organization's needs" (p. 341). Hansen and Goldberg perceived the emergence of managed care systems as often adding another level of complication to the ethical decision-making process.

When counselors find themselves in difficult systems, Corey et al. (2003) recommended a proactive course of action. This recommendation is in keeping with the ACA's (2005) code of ethics that states:

> Counselors alert their employers of inappropriate policies and practices. They attempt to effect changes in such policies or procedures through constructive action within the organization. When such policies are potentially disruptive or damaging to clients or may limit the effectiveness of services provided and change cannot be effected, counselors take appropriate further action. Such action may include referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment. (Section D.1.h.).

Hansen and Goldberg (1999) recommended counselors review employment and insurance panel contracts carefully before beginning services.

Process Ethics

Process ethics, as a perspective in ethical decision making, has recently emerged in mental health literature. H. Anderson (2001), T. Anderson (2001), Gergen (2001), Ray (2001), and Swim, St. George, and Wulff (2001) have all written about process ethics. Swim et al. described process ethics as the "respectful and meaningful interpersonal space between therapist and client" (p. 14). According to Gergen, the concepts of process ethics are "as exciting in implication as [they are] ambiguous in

articulation" (p. 7). Gergen believed the ambiguity allows for generation and evolution of new perspectives and ideas he envisions will enrich ethics dialogue. Ray described process ethics as encompassing "both one's mind and one's heart" (p. 27). According to Ray, the essence of process ethics is about holding a strong code of ethical conduct without losing the compassion of a tender heart. In following the process ethics perspective, counselors integrate traditional mandatory ethics with an ability to hear and encourage the voice of the client (Ray).

Swim et al. (2001) contended ethical decision making is a process of exploration with the client in an effort to find viable alternatives. In process ethics the ethical decision-making process becomes "collaboration between content and process ethics" (Swim et al. p. 19). The three main components of process ethics listed by Swim et al. are relational connectedness, full presence, and sacred conversations. Relational connectedness refers to the shared power of therapist and client defining treatment direction. Full presence refers to honest, caring, and humble presence of the therapist that enables the development of trust. Sacred conversations "refers to the practice of seeing conversations with clients as worthy of the highest respect and reverence" (p. 16).

H. Anderson (2001) asserted mental health professionals have traditionally developed ethical codes and standards without a relational and communal dimension that is put forth within the process ethics perspective. For Gergen (2001), traditional or content ethics are limited and not easily negotiated. He saw traditional ethics as saying to the therapist, "if you go beyond this limit, you are no longer one of us" (p. 8).

Gergen contended openness in relationship is central to the therapeutic and ethical decision-making processes and openness as described by process ethics is not possible within content ethics limitations.

Ethical Decision-Making Models

There are a number of ethical decision-making models presented in mental health literature (Betan, 1997; Canadian Psychological Association, 1991; Capuzzi & Gross; 1999; Cohen & Cohen, 1999; Corey et al., 2007; Cottone, 2001, 2004; Forester-Miller & Davis, 1996; Garcia, et al., 2003; Hansen & Goldberg, 1999; Hare, 1981; Haas & Malouf, 1995; Hill et al., 1995; Kenyon, 1999; Kitchener, 1984b, 2000; Koocher & Keith-Spiegel, 1998; Loewenberg & Dolgoff, 1996; Mattison, 2000; Remley & Herlihy, 2005; Rest, 1984, 1994; Sileo & Kopala, 1993; Stadler, 1986; Steinman, 1998; Tarvydas, 1998; Tymchuk, 1981; Welfel, 2006; Woody, 1990). According to Neukrug et al. (1996) and Hill (2004a), ethical decision-making models are specific approaches to resolving ethical dilemmas requiring decision-making guidelines outside what codes are designed to address. Hill pointed out that ethical decision-making models are important and even central to the teaching of ethics in academic training programs.

There have been criticisms of ethical decision-making models. Welfel (2006) and Haas and Malouf (1995) acknowledged models tend to be cumbersome, others (Corey et al., 2003; Hill, 2004a; Remley & Herlihy, 2005) have attempted to dispel the traditionally linear approach to ethical decision-making models, and Hill, et al. (1995)

expressed their concern about the non-relational tone in traditional models. Hill et al. and Garcia et al. (2003) have expressed their concern that traditional ethical decision-making models are not multiculturally sensitive.

Cottone and Clause (2000) divided decision-making models into theory-based and practice-based models. Theory-based models are those in which authors "made an attempt to ground ethical decision making on some theory or philosophy" (Cottone & Clause, p. 276). Practice-based models are those in which authors "have proposed models based on pragmatic procedures derived largely from experience or intended primarily as practical guides for counselors" (Cottone & Clause, p. 278).

The first and second sections of this review of ethical decision-making models follow the Cottone and Clause (2000) division of theory-based and practice-based models. The first section reviews the three primary theory-based models of Rest (1984, 1994), Kitchener (1984b, 2000), and the feminist model presented by Hill et al. (1995). The second section presents the four primary practice-based models used in training professional counselors, which are the models of Forester-Miller and Davis (1996), Remley and Herlihy (2005), Welfel (2006), and Corey et al. (2007). Both sections include a brief discussion of secondary or incidental models. A discussion of research-related ethical decision-making models forms the third section of this review of ethical decision-making models.

The final section reviewing ethical decision-making models delineates common components found in theory and practice-based models reviewed in this chapter. The fourth question of this study called for a comparison between the ethical decision-

making process of practicing professional counselors participating in the study and ethical decision-making models found in metal health literature. The primary theory-based and practice-based models and their common components reviewed in this section form the basis of comparing ethical decision-making models currently found in the literature and the research data reported in Chapter 4.

Theory-Based Models

Rest's Four Psychological Components Determining Moral Behavior

Stein (1990) indicated the four-component model put forth by Rest (1984) is a model worth careful consideration. According to Cottone and Claus (2000), the frequently referenced Rest (1984, 1994) model provides a framework for moral understanding, decision making, behavior, and education. Rest (1984) indicated his intent was to present a model that described the "processes involved in the production of moral behavior" (Rest, p. 19) and drew heavily on the theories and research from the field of moral development. Although the Rest model has been applied to a variety of professional disciplines, it was initially developed for application to the ethics of psychology (Cottone & Claus, 2000). Rest offered a revised model in 1994. The Rest model is summarized in Table 1.

Component I: Moral sensitivity. Rest (1984, 1994) defined moral sensitivity as one's ability to interpret situations. Interpretation of situations includes consideration of the individual(s) involved, knowing the possible and/or available actions, and understanding how each potential action could impact client welfare. Moral sensitivity

Table 1

Rest's Four Psychological Components Determining Moral Behavior

Component Identification		Component Description
I.	Moral sensitivity	Interpreting the situation
II.	Moral judgment	Judging which action is morally right/wrong
III.	Moral motivation	Prioritizing moral values relative to other values
IV.	Moral character	Having courage, persisting, overcoming distractions, implementing skills

Note. Adapted from Background: Theory and Research by J. R. Rest. In *Moral Development in the Professions* (p. 23), by J. R. Rest and D. Narváez, 1994, Hillside NJ: Lawrence Erlbaum Associates, Inc. Copyright 1994 by Lawrence Erlbaum Associates, Inc.

requires counselors to have the ability to identify the difficulty, generate possible scenarios, demonstrate empathy, and project how the reality of cause and effect could potentially unfold in each of the possible actions (Rest, 1994).

Moral sensitivity includes both cognitive understanding and affective reaction. Some situations will call forth strong feeling responses that may cause a person to "proceed without waiting for a considered judgment and careful weighing of the facts" (Rest, 1984, p. 21). These strong reactions can sometimes direct individuals to higher moral action, but, at other times, Rest cautioned these responses may hinder good judgment. Rest underscored the reality that morally sensitive interpretation is a complex matter and individuals will sometimes even find difficulty interpreting what might be considered simple situations.

Component II: Moral judgment. Moral judgment is about assessing and prioritizing possible actions generated in Component I to determine which "is more morally justifiable (which alternative is just, or right)" (Rest, 1994, p. 24). The assessing and prioritizing process involves studying the various, sometimes conflicting, aspects of the situation, and then developing a rationale for selection of the best moral action.

According to Rest (1984), selecting a course of action can be biased by pressure for individual or institutional gain. Rest indicated individuals are usually aware of the influence which desire for personal or institutional success brings to the process of selecting a course of action. He believed this awareness could create a conflict between non-moral and moral values. Rest cautioned that lack of attention to

conflicting values, simplistic rationalization, or in-depth decision making could create a weakness in the process of selecting a moral course of action.

Component III: Moral motivation. Moral motivation is an internal process involving an intentional decision to prioritize moral values relative to other values. The weakness in moral motivation emerges when individuals fail to implement moral action because personal or institutional concerns take precedence. Rest (1984) maintained it is not unusual for individuals to experience the power of non-moral values that can pull individuals toward decisions which compromise moral values and actions.

Component IV: Moral character. Moral character involves implementation of a plan of action. Successful implementation of Component IV requires individuals to outline probable action steps, be persistent in pursuing the chosen moral action, and maintain diligence in focusing on the goal in spite of distractions. Moral sensitivity, the insight to make good moral judgments and ability to place a high priority on moral values, will not guarantee a successfully completed moral action. Moral failure occurs when people lack courage, focus, and/or personal strength to fully implement action. "Perseverance, resoluteness, competence, and 'character' are virtues of Component IV" (Rest, 1984, p. 26).

Rest (1984, 1994) did not intend the components to be viewed, taught, or used as sequential steps in a linear format. The components were designed to be interactive elements influencing each other within the process that determines moral behavior.

Rest did caution that at times the interaction between components could lead to moral compromise.

> As the costs of moral action come to be recognized, a person may distort the feelings of obligation by denying the need to act, by denying personal responsibility to act, or by reappraising the situation so as to make the other alternative actions more appropriate. In other words, as subjects recognize the implications of Component II and Component III processes and the personal costs of moral actions become clear, they may reappraise and alter their interpretation of the situation (Component I) so that they can feel honorable but at less cost to themselves. (1984, p. 27)

Rest (1994) noted individuals have varying levels of moral development. Each person differs in strengths and weaknesses in processing and/or carrying out the various components. Additionally, each situation calls for its own understanding, process, and emphasis within the components. Therefore, a varied pattern for emphasis on each component may emerge depending upon the individual decision maker and situation in question.

Kitchener: Intuition, Critical Evaluation and Ethical Principles

Kitchener published "a seminal work related to ethical decision making in counseling and counseling psychology" (Cottone & Claus, 2000, p. 275) in 1984. Subsequent to this critical contribution to thinking about ethical decision making and mental health professionals, Kitchener has continued to offer direction to the professional in the area of applied ethics (1991, 1996) and ethics training (1986, 1992, 2000). The model as represented in her 2000 text does not differ in structure from the model presented in 1984. The 2000 text does, however, offer more extended

discussion concerning rationale and thinking behind the model and its application. The model is summarized in Figure 1.

Kitchener's model was designed to "suggest that there are different levels of moral reasoning and that they are hierarchically related" (2000, p. 11). Awareness of the clinical situation plus the counselor's own developed moral self, what Kitchener called "ordinary moral sense" (Kitchener, 1984b, p. 45), combine to form the first level of the Kitchener model. This is referred to as the intuitive level or the immediate level of moral reasoning. In the development of her ideas for the intuitive or immediate level of moral reasoning of ethical decision making, Kitchener drew upon the work of Hare (1981). Individuals are operating on the first level of ethical decision making when they "have an immediate, prereflective response to . . . ethical situations based on the sum of their prior ethical knowledge and experience" (Kitchener, 1984b, p. 44). Within the course of professional life, counselors encounter situations for which they have had no prior specific training and there is no direct rule to guide them (Kitchener, 1984b, 2000). In these situations, Kitchener argued counselors draw upon their own good moral sense. However, Kitchener is insistent that our moral senses are, in some situations, not enough to accomplish the requirements of complex decision-making processes.

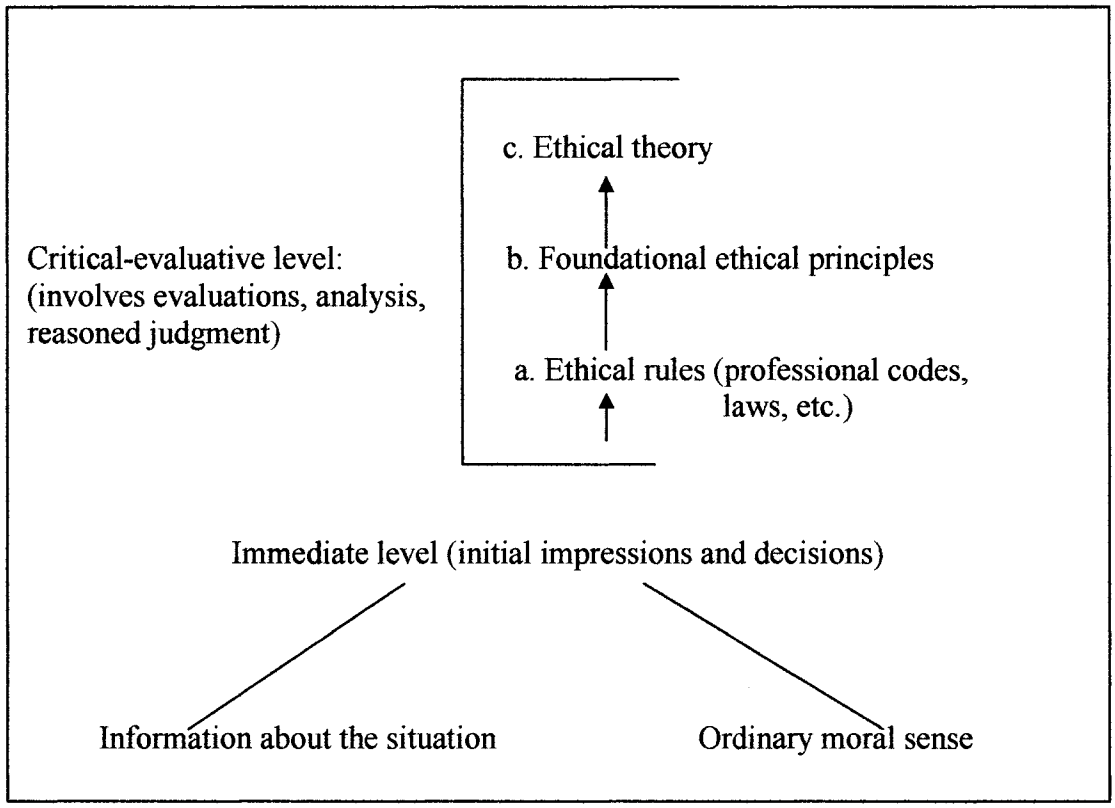

Figure 1. Kitchener: A Model of Ethical Justification

From *Foundations of Ethical Practice, Research, and Teaching in Psychology* (p. 11), by K S Kitchener, 2000, Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers. Copyright 2000. Copyright 2000 by Lawrence Erlbaum Associates.

The "critical-evaluative" level or second level of moral reasoning in Kitchener's model is needed when the intuitive level is inadequate to navigate a particular ethical dilemma. The critical-evaluative level is a three-tiered process moving from specific to more general or abstract forms of decision making. The first tier includes professional rules found in codes and laws. The second tier is composed of foundational ethical principles. When both professional rules and foundational ethical principles fail to fully address issues in a particular clinical situation, professionals "must be guided by ethical theory and reasoned judgments about where the weight of the argument lies" (Kitchener, 2000, p. 12). Ethical theory is thus the third and final tier in the critical-evaluative level.

Kitchener (1984b, 2000) proposed five ethical principles as central to ethical thinking for the practice of mental health counseling. These five principles are "beneficence (do good), nonmaleficence (do no harm), autonomy (respect others' choices), justice (be fair), and fidelity (keep promises, do not lie, be faithful)" (Kitchener, 2000, p. 12). Although Beauchamp and Childress (1979, 2001) and Meara et al., (1996) listed principles that differ slightly from these five, Kitchener argued these principles speak to the foundational ethical norms that are core to clinical practice for mental health professionals (Kitchener, 2000).

The Feminist Model Presented by Hill, Glaser, and Harden

Feminist principles are foundational to the Hill et al. (1995) presentation of their feminist ethical decision-making model. Their stance on Kitchener's (1984b) intuition

and critical–evaluative thinking levels, including the decision-making influence of ethics codes and moral principles, is one of respectful caution. The caution reflects the authors' fundamental concern that intuitive thinking is based in the cultural perspective that has often added to a power differential weighted against women and "other historically undervalued groups" (Hill et al., p. 20). They argued that culturally biased applications of intuition, codes, and principles have been harmful to female clients.

Distinctions of feminist ethical decision making include attention to the power differential inherent in therapeutic relationships, a consistent stress on working with clients throughout the process of resolving ethical dilemmas, and an emphasis on ethical decision-making as non-linear by nature. Additionally, the feminist model continually calls counselors to evaluate the impact their own culturally influenced values, characteristics, and experiences may have on therapeutic relationships.

Hill et al. (1995) presented their model as an integration of the rational-evaluation process found in more traditional decision-making models and the feeling-intuitive process that is core to understanding and implementing the Hill et al. model. The model is an interplay between thinking and feeling, and feeling and thinking. Each step builds upon this interplay and contains encouragement to attend to the influence of personal characteristics, values, and the use of power in the clinical relationship. In presenting steps for their model, Hill et al. described the decision-making process as a weaving "back and forth between a more cognitive evaluation of the dilemma and attention to the clinician's experiential or feeling sense of the situation" (p. 28).

Recognizing the problem. Recognition of an ethical concern is based in knowledge of therapeutic process, ethical codes, and/or a general understanding of ethics and professional conduct. Hill et al. (1995) asserted that a fundamental "task of the therapist is to identify any aspects of her or his feelings that stand in the way of understanding and sorting through the problem" (p. 28). The authors suggested counselors sometimes feel conflicted and/or experience a sense of shame when encountering a situation for which they need assistance. They observed that this conflict and/or sense of shame may emerge from a belief that professionals should not need help in sorting out ethical concerns.

Defining the problem. Inherent in ethical dilemmas is conflict between some aspect of ethics and clinical understandings. The task in this step is to clarify the conflict. For Hill et al. (1995) it is critical for counselors to collaborate with clients in this process of clarification. Counselors are also encouraged to attend to their own values, characteristics, and life experiences, as these may influence how they understand and define dilemmas. Within the feminist's model, counselors are instructed to consider supervisor values that may influence the decision-making process.

Developing solutions. The task of this step is to generate possible actions to resolve the dilemma. Counselors are encouraged to attend to any feelings that emerge around action plans. Hill et al. (1995) contended these feeling responses are useful for continued insight as counselors move through the decision-making process. When

clinically appropriate, clients are included in this process of generating options for resolution.

Reviewing the process. Counselors are encouraged to review the path they have selected to resolve a given dilemma. In discussing this review process, Hill et al. (1995) again emphasized attending to possible influence of personal values and characteristics. Recognizing the power differential between counselor and client and assessing potential misuse of power is critical during this step. Hill et al. suggested two reflective measures for guarding against inappropriate application of values and/or misuse of power. First, they encouraged counselors to reflect on how comfortable they would be if their selected decision were shared with colleagues. Second, they suggested counselors think about the feasibility of applying selected actions in other similar clinical situations.

Implementing and evaluating the decision. Counselors implement the decision while monitoring the consequences that follow. The primary consideration in this step is the response of clients at each point in the process of implementation. Hill et al. (1995) emphasized the importance of counselor involvement, where possible, in ongoing assessment(s) of the intervention(s) leading to resolution.

Continuing reflection. Hill et al. (1995) asserted experience changes all parties involved in a given situation. In this final step, they stressed the importance of reflection, contending the use of reflection leads to increased self-knowledge and enriched future clinical work.

Selected Secondary Theory-Based Models

Hare. In 1981 Hare proposed a two-step model for ethical decision making that Kitchener (1984b) drew upon in developing her model. Hare recognized that mental health professionals need to grapple with a range of simple and complex ethical difficulties. He believed that the intuitive level was the everyday operational level at which professional situations generally are resolved. However, he argued intuition is insufficient to address the more complex questions involved in considering the rights and interests of clients. Hare maintained a higher level of thinking, which he called "critical moral thinking" (p. 33), was necessary when addressing the more complex areas of professional practice. He described higher level thinking as the point "at which we select the principles to be used at the intuitive level, and adjudicate between them in cases where they conflict" (Hare, p. 36). Hare's work was developed for application to psychiatric ethics but has had significant impact on counseling ethics, with Kitchener and many others drawing upon his ideas (Cottone & Claus, 2000).

Betan: Hermeneutic model of ethical decision making (1997). Betan (1997) presented a model that integrates the moral reasoning models of Kitchener (1984b) and Rest (1984) with a "hermeneutic perspective" (Betan, p. 357). According to Betan, hermeneutic perspective makes room for an interpretative interactive process of ethical decision making anchored in the context of therapeutic relationships. Betan challenged the traditional non-relational and linear moral reasoning models and suggested a more relational and interactive model without eliminating moral reasoning from the decision-making process. Foundational to the hermeneutic perspective is a

consciousness of the contextual dynamics of the particular therapeutic relationship involved, and an understanding of the experiences and values counselors bring to therapeutic relationships, all of which influence the decision-making process.

Cohen and Cohen: The virtuous therapist framework for ethical-decision making. Cohen and Cohen (1999) offered a framework for conceptualizing decision making that uses five interdependent stages. The framework is "based upon consideration of the welfare, interests, and needs of clients and relevant others" (p. 35). The stages are listed in Table 2.

The distinguishing feature of this model is the emphasis on moral thinking and action. In the first stage, the emphasis is on identifying and defining the moral difficulty. In this first stage, the primary focus is on the aspects of the dilemma directly involving the wellbeing of the individual(s) being served. The second stage involves the gathering of a client history including medical records, previous counseling, and relevant socioeconomic considerations such as financial status, family concerns, and religious beliefs. Cohen and Cohen (1999) defended using the phrase "morally relevant facts" (p. 38) as a means of keeping the ethical decision-making process focused on moral aspects of ethical problems. The third stage is a reflective exercise. Cohen and Cohen contended that "a basic principle undergirding the practice of a virtuous therapist . . . is that of *moral considerateness*" (p. 39).

Table 2

Cohen and Cohen: The Virtuous Therapist Framework for Ethical Decision Making

Stage	Moral Consideration and Task
1	Identifying and Defining Moral Problems
2	Identifying Morally Relevant Fact
3	Conducting a Philosophical Analysis of the Defined Problem in Light of All Morally Relevant Facts
4	Reaching a Decision That Is Reasonable in Light of Philosophical Analysis
5	Implementing the Decision in Action

Note: Adapted from *The Virtuous Therapist: Ethical Practice of Counseling and Psychotherapy* (pp. 35-47), by E. D. Cohen and G. S. Cohen, 1999, Belmont, CA: Brook/Cole. Copyright 1999 by Wadsworth Publishing Company.

Stages four and five deal with making and implementing a decision for resolution of the concern. These decision-making stages involve using rational judgment, patience, professional standards, consideration of laws, and attending to agency or institutional policy. Cohen and Cohen (1999) contended that when the situations call for it virtuous therapists will "be prepared to challenge agency policies that they reasonably believe are contrary to client welfare, even at risk of losing their jobs" (p. 44).

Cottone: Social constructivism.. The social constructivism model of ethical decision making proposed by Cottone (2001, 2004) is based in the theory that decision making is a social and not a psychological process. A social constructivism perspective is grounded in the idea that all actions take place in social context and all decisions involve social interaction (Cottone). Consequently, "social constructivism ethical decision making is a process of negotiating (when necessary), consensualizing, and arbitrating (when necessary), that occurs in the interpersonal process of relations that come to bear at critical moments of professional practice" (Cottone, 2001, p. 42). Cottone (2001) argued that professional counselors are less vulnerable in ethically challenging situations when decisions are formed through intentional interaction with an ethically grounded professional community.

Practice-Based Models

Forester-Miller and Davis: A Practitioner's Guide

The Forester-Miller and Davis model (1996) was developed under the auspices of the ACA Ethics Committee. The model is presented on the ACA web site and in published booklet form (1996). According to the booklet, the Forester-Miller and Davis guide for ethical decision-making for practitioners is intended to provide counselors with a "framework for sound ethical decision making" (p.1). The framework includes a brief discussion of moral principles and a seven-step model for ethical decision making. The seven steps were proposed as a guide for counselors during situations in which codes and moral principles are found insufficient for resolving ethical dilemmas.

The moral principles offered by Forester-Miller and Davis (1996) are the same as those put forth by Kitchener (1984b). Forester-Miller and Davis contended these particular moral principles are foundational to their ethical decision-making framework. The authors suggested counselors begin the decision-making process with a review of relevant moral principles. They argued such a review will often assist counselors in clarifying ethical concerns. When a review of the principles does not provide enough clarity to resolve the dilemma, Forester-Miller and Davis encouraged counselors to proceed through the steps of the model.

The first two steps of this model deal with identification of the problem and application of the code of ethics. Forester-Miller and Davis (1996) suggested that in

less complex situations, these two steps often lead to resolution. If a satisfactory plan for resolution is not clear after applying the first two steps, the authors suggested the situation is likely an ethical dilemma and will require working through steps three through seven.

The third step in this model is to "determine the nature and dimensions of the dilemma" (Forester-Miller & Davis, 1996, p. 5). This step may include any or all of the following four components: prioritizing principles for the situation in question, reviewing relevant literature, consulting with supervisors and/or colleagues, and contacting state or national associations.

Steps four through seven form the action phase of this model. Step four involves generation of possible actions. Step five requires counselors to project and evaluate possible consequences for each action option. Within this step counselors evaluate and eliminate until a suitable course of action is determined. Step six asks counselors to further "evaluate the selected course of action" (Forester-Miller & Davis, 1996, p. 6). Counselors are encouraged in step six to apply tests of justice, publicity, and universality to the potential action plan. The authors summarized Stadler (1986), who suggested the following procedures to accomplish this task.

> In applying the test of justice, assess your own sense of fairness by determining whether you would treat others the same in this situation. For the test of publicity, ask yourself whether you would want your behavior reported in the press. The test of universality asks you to assess whether you could recommend the same course of action to another counselor in the same situation. (Forester-Miller & Davis, p. 6.)

When counselors are able to answer affirmatively to these questions, they are ready to move to the final step.

Step seven is the actual implementation of the intervention selected to resolve the ethical difficulty. If a positive assessment can not be given for the tests of justice, publicity, and universality, the authors suggested counselors go back to step one and reconsider the process step by step. Forester-Miller and Davis noted that different professionals select different actions to resolve various dilemmas and the notion of there being one correct solution to any complex ethical dilemmas is unfounded.

Remley and Herlihy: Common Elements in Ethical Decision Making

According to Remley and Herlihy (2005), their model is not a step-by-step process, but rather a presentation of the components common to models of ethical decision making found in professional counseling literature. In their discussion of ethical decision-making models, they pointed out that traditionally "models have tended to be linear, logical, rational, dispassionate, abstract, and paternalistic" (p. 12). According to Remley and Herlihy, traditional formats for ethical decision making are reflective of moral decision-making patterns typically associated with white males. Remley and Herlihy indicated their desire was to promote a culturally sensitive ethical decision-making style that would allow for differing patterns of moral decision making. They argued that their holistic approach makes room for intuition, emotion, compassion, context, and mutuality.

The authors (Remley & Herlihy, 2005) embedded their model for ethical decision making in their greater model for professional practice. Their professional practice model encourages counselors to balance their own internal courage, skills,

and knowledge with the external resources of the professional community. These external resources include supervision, consultation, continuing education, relevant laws, codes of ethics, and the policies of the particular agency or institution of employment. The Remley and Herlihy practice model is illustrated in Figure 2.

Remley and Herlihy (2005) contended the elements they selected to present as foundational to ethical decision making are aligned with the thinking of feminist theory and consistent with principle and virtue ethics. The authors listed eight elements for consideration in the ethical decision-making process. Although Remley and Herlihy did not directly propose a formal ethical decision-making model, their outlined structure, which places the ethical decision-making process within the context of professional practice, and their high profile in the area of counselor ethics, makes their work important to this study. The elements are listed in Table 3.

The first element discussed by Remley and Herlihy (2005) for the decision-making process involves recognition and definition of the ethical concern. The authors encouraged counselors not to get caught up in unnecessary panic, but to take time for information gathering and reflection. Within this element the information gathering may include a reviewing relevant literature, codes, and/or laws.

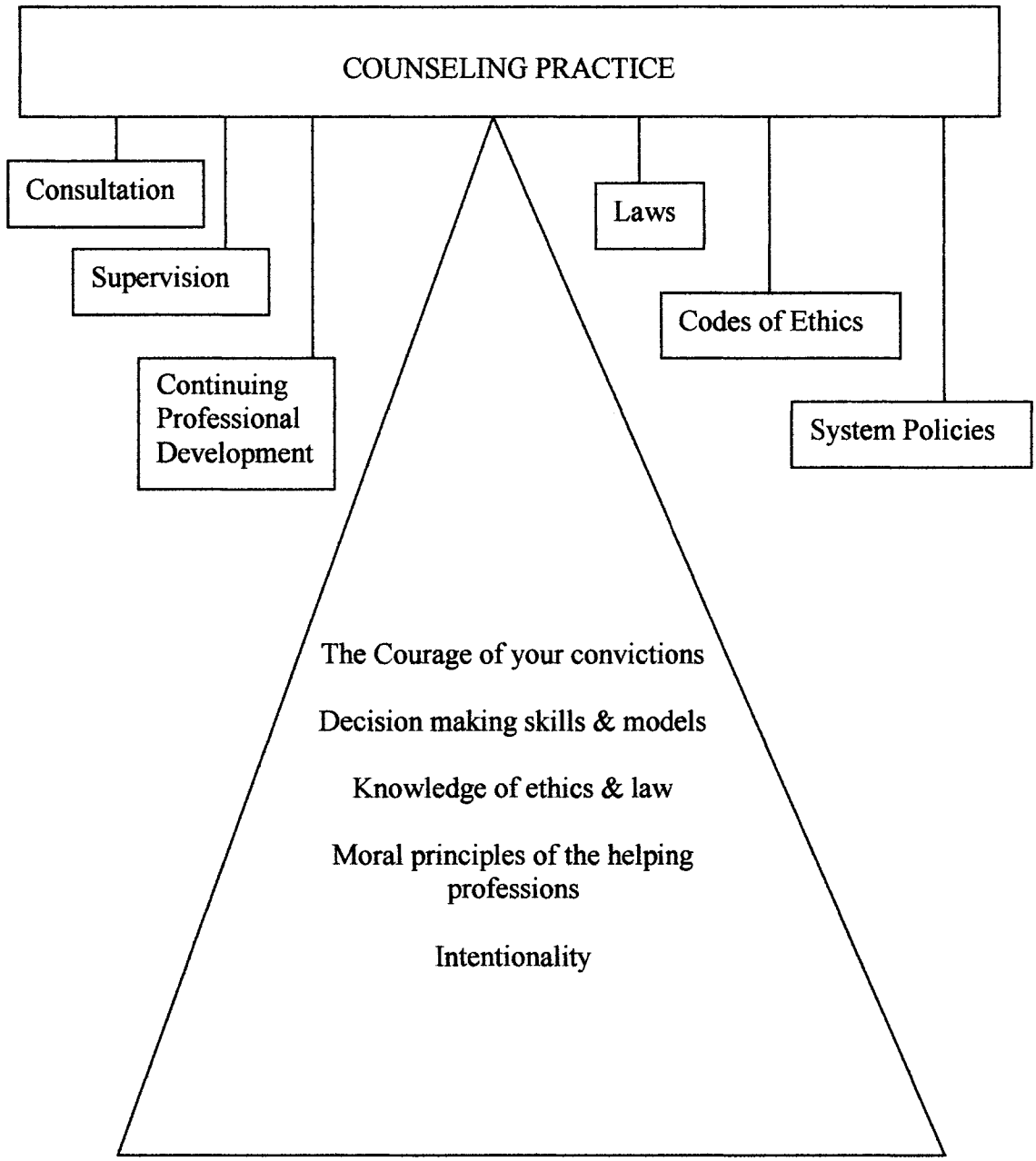

Figure 2. Professional Practice – Built from within and balanced from outside the self

Note: Adapted from *Ethical, Legal, and Professional Issues in Counseling* (p. 4), by T. P. Remley and B Herlihy, 2005 (2nd ed.), Upper Saddle River, NJ: Merrill Prentice Hall. Copyright 2001 by Prentice-Hall, Inc.

Table 3

Remley and Herlihy: Common Ethical Decision-Making Process Elements

Elements
Identify and define the problem
Consider the moral principles
Tune in to your feelings
Consult with colleagues or experts
Involve your client in the decision-making process
Identify desired outcomes
Consider possible actions
Choose and act on your choice

Note. Adapted from *Ethical, Legal, and Professional Issues in Counseling* (2nd ed.) (p. 13), by T. P. Remley and B. Herlihy, 2005, Upper Saddle River, NJ: Merrill Prentice Hall. Copyright 2001 by Merrill Prentice Hall.

The second and third elements concern internal reflection. The second addresses consideration of moral principles, including "autonomy (respecting freedom of choice), nonmaleficence (doing no harm), beneficence (being helpful), justice (fairness), fidelity (being faithful), and veracity (being honest)" (Remley & Herlihy, 2005, p. 4). The third element encourages counselors to be intentional about listening to and understanding their feelings related to the situation in question. According to Remley and Herlihy, this self-examination process is important because it may uncover life experiences and emotional responses that could potentially influence the decision-making process.

The fourth element encourages counselors to consult colleagues. The authors argued that decisions made "in isolation are rarely as sound as decisions made in consultation" (Remley & Herlihy, 2005, p. 13). They also underline the benefit of consultation in the event a counselor should face legal action.

Involving the client in the ethical decision-making process is the fifth element discussed by Remley and Herlihy (2005). The authors emphasized the need for counselors to include the client whenever possible during the decision-making process. They contended involving clients in the process is empowering and is culturally appropriate.

The sixth, seventh, and eighth elements deal directly with taking action to resolve the dilemma. The fifth element is to "identify desired outcomes" (Remley & Herlihy, 2005, p. 13). The sixth element involves considering possible actions that

could be taken to achieve the desired outcome(s). Finally, the seventh element requires counselors to select and implement an action.

Following application of these common elements and the resolution of the dilemma, Remley and Herlihy (2005) suggested "applying four self-tests" (p. 14) to reflect on the process. These four self-tests address justice, universality, publicity, and moral traces, and involve asking critical questions in each of the areas. During this time of reflection counselors are encouraged to contemplate whether or not they would apply the same actions to other similar situations, recommend the course of actions to colleagues, be willing to have their actions made public, and listen to any feelings emerging around the decision and action. Remley and Herlihy acknowledged that post-decision feelings or moral traces may be uncomfortable, especially when "expediency, politics, or self-interest have influenced the decision" (p. 14) but insisted counselors allow their internal comfort or discomfort be embraced as preparation for future ethically demanding situations.

Welfel: Ten-Step Model for Ethical Decision Making

The model Welfel (2006) set forth is a ten-step process built on the intuitive and critical-evaluative ethical judgment dimensions of the Kitchener (1984b) model. In presenting her ten-step model, Welfel acknowledged that models and steps are time-consuming, cumbersome, and often impractical in a step-by-step format within the time constraints of the real-world situations counselors encounter when facing ethical dilemmas. However, she argued that applying complicated, yet necessary, ethical

decision-making processes is expedited when counselors have "done their ethics homework" (p. 23). The Welfel model is summarized in Table 4.

The first step of the Welfel (2006) model involves development of ethical sensitivity. Foundational to this step is formal education in ethics, a working knowledge of ethics literature and standards, and continuing education training in ethics. Welfel indicated practice in confronting hypothetical dilemmas provides the tools necessary for informed ethical sensitivity. She stressed "personal principles and philosophy consistent with the profession" (p. 24) are integral to professional ethical sensitivity and agreed with Jordan and Meara (1990) that before counselors can be ethical professionals, they must first be virtuous individuals. Welfel acknowledged that in the everyday demands of clinical work it is easy for the counselor to overlook ethical concerns and suggested adding a line for ethical considerations to intake forms and case notes as a practical step to increase ethical sensitivity.

The second step involved identifying and clarifying sociocultural context. This requires organizing case information including identifying "stakeholders" (p. 25) and the impact counselor interventions may have on others involved in the client's life situation. Welfel (2006) states, "The welfare of the other stakeholders cannot take priority over the welfare of the client, but the goal of the counselor is to consider options in which the welfare of all stakeholders can be protected if possible" (p. 26).

Table 4

Welfel: Ten-Step Model for Ethical Decision Making

Step Number	Step Activity
1	Develop ethical sensitivity/ Become sensitive to the moral dimensions of counseling
2	Clarify facts and sociocultural context of the case/ Identify the relevant facts and stakeholders
3	Define the central issues and the available options
4	Refer to professional standards and relevant laws/regulations
5	Search ethics scholarship
6	Apply ethical principles to the situation
7	Consult with supervisor and respected colleagues
8	Deliberate and decide
9	Inform supervisor; implement and document actions
10	Reflect on the experience

Note: Adapted from *Ethics in Counseling and Psychotherapy: Standards, Research, and Emerging Issues* (3rd Ed.) (p. 22), by E. R. Welfel, 2006, United States: Brooks/Cole. Copyright 2002 by Wadsworth Group.

Steps three and four of Welfel's (2006) model involve specific applications of ethics training and knowledge. The third step requires identification of the problem and development of possible courses of action. For Welfel, this step builds upon an assumption that counselors attend to ethical concerns and have training that has prepared them to generate potential responses. Welfel recommended counselors document their process and reasoning by keeping a written record of identified concerns and potential responses. The fourth step in this model requires the counselor to examine ethics codes and appropriate legal regulations and rulings. Welfel acknowledged, within her discussion of this step, the reality of potential conflicts within codes and between codes and the law.

When neither codes nor law provide clear and satisfactory guidance, counselors need to move to step five that examines pertinent professional literature. Welfel (2006) pointed out that searching relevant literature provides a significant resource for counselors who may feel isolated or vulnerable in a given circumstance. Consulting the literature also assists counselors in providing a rationale for their actions and decisions to supervisors and others involved in, or perhaps, even challenging their clinical decision. She further argued that "knowledge of this literature is a necessity, not a luxury, for a competent counselor, especially when dealing with an ethical issue that is common to a population or setting" (p. 31).

When these first five steps have not led to a conclusive decision about action, counselors need to move to step six. This next step requires counselors to strive to understand fundamental ethical principles underlying the particular difficulty and, if

necessary, apply ethical principles theory. Within this step, Welfel (2006) encouraged application of the standard principles discussed by Kitchener (1984b) with the understanding that in some situations principles conflict. When principles are in conflict and/or consideration of principles does not bring resolution, counselors need to turn to ethical theory. Welfel pointed out that ethical theories assist in exploring differing presuppositions about the basic nature of moral behavior and suggested the following.

> For the most complex dilemmas, in which a counselor agonizes about the process and in which each alternative seems to have negative consequences, thinking about how he or she defines morality at the most basic level may help in resolving the dilemma. (p. 38)

The seventh step in the Welfel (2006) model is consultation with colleagues. This may involve a short-term or intermittent consulting relationship, an ongoing supervision arrangement, and/or using professional organizational services. Although this component is listed as the seventh step, Welfel encouraged counselors to see consultation as a step that may take place at various points in the ethical decision-making process.

Step eight directs the counselor to take time for independent reflection. At this point the process of defining the dilemma, reviewing codes and laws, searching relevant literature, and consulting colleagues is finished. According to Welfel (2006), counselors must now sort the gathered information and counsel before deciding which potential course of action is most ethical. Developing a plan to implement the selected action is the final task in step eight and requires some forethought concerning the potential difficulties that might be encountered when carrying out the plan.

Step nine requires the implementation of the decision. However, before action is taken, all relevant individuals need to be informed of the decision. According to Welfel (2006), it is the legal and ethical right of a supervisor to be informed of the selected decision and rationale. Primary consideration in dissemination of information is to be given to the client but there may be others who will also need to be informed. When clients are legal dependents, it may be necessary to inform legal guardians. Information concerning potential action should be shared with any person who may be placed at risk as a result of implementation of the decision. Welfel indicated that step nine may necessitate further consultation and/or call for ethical courage.

Step ten is a time of reflection. Welfel (2006) contended "experience without reflection is wasted" (p. 41). Counselors are directed to take time following implementation of the selected action as an intentional step of professional growth.

Corey, Corey, and Callanan: Eight Steps in Ethical Decision Making

Corey, Corey, and Callanan (2007) preface their eight-step model with some basic concepts for consideration in the application of their model. In the presentation of their model Corey et al. stated, "ethical decision making is not a purely cognitive and linear process that follows neatly step by step" (p.19), pointed out that the ethical decision-making process is a value-laden process, and highlighted the need for counselors to be conscious of both their own and their clients' values. Referencing the feminist model (Hill et al., 1995), Corey et al. discussed counselor emotions as influential in the ethical decision-making process. Involving the client in the ethical

decision-making process whenever appropriate is another concept Corey et al. stressed as important to implementation of their model. The eight steps are summarized in Table 5.

The first and second steps of the Corey et al. model (2007) are related to issues of problem identification. The first step is the actual recognition or identification of the difficulty. It includes information gathering, which Corey et al. contended leads counselors to a clear comprehension of the ethical, legal, professional, and/or moral dimensions of dilemmas. Within this step counselors are encouraged to begin involving clients in the decision-making process as soon as a difficulty is identified. The second step involves identification of "potential issues involved" (Corey et al., p. 21). Step two includes prioritization and application of moral principles. The authors listed six moral principles that include the five moral principles outlined by Kitchener (1984b) plus the principle of veracity. Corey et al. indicated the moral principle of veracity or truthfulness is important to diagnosis, informed consent, and office policies.

Steps three, four, and five involve consulting professional resources. During step three counselors review ethics code(s) applicable for the particular situation. Cory et al. (2007) leave room for disagreement within the codes provided counselors have a developed rationale to support their alternate view and course of action. In step four counselors examine and apply laws and/or regulations pertinent to the specified clinical scenario and/or work setting involved. During step five counselors consult with colleagues and when necessary seek legal counsel.

Table 5

Corey, Corey, and Callanan: Eight Steps for Ethical Decision Making

Step Number	Step Activity
1	Identify the problem or dilemma
2	Identify the potential issues involved
3	Review the relevant ethics codes
4	Know the applicable laws and regulations
5	Obtain consultation
6	Consider possible and probable courses of action
7	Enumerate the consequences of various decisions
8	Decide on what appears to be the best course of action

Note. Adapted from *Issues & Ethics in the Helping Professions* (7th Ed.) (p. 20-22), by G. Corey, M. S. Corey, and P. Callanan, 2007, United States: Brooks/Cole. Copyright 2007 by Wadsworth Group.

The final three steps relate to action. Step six entails generation of probable actions. Step seven requires counselors to evaluate the implications of each probable action they have generated. The eight and final step is selection of "what appears to be the best course of action" (Corey et al., 2007, p. 23).

Selected Secondary Practice-Based Models

In addition to the primary practice-based models reviewed in the previous section, there are a number of secondary practice-based models that have been presented within mental health literature including the Canadian Psychological Association (1991), Garcia, et al. (2003), Haas & Malouf (1995), Hansen & Goldberg (1999), Koocher & Keith-Spiegel (1998), Kenyon (1999), Loewenberg & Dolgoff (1996), Mattison (2000), Sileo & Kopala (1993), Stadler (1986), Steinman, (1998), Tarvydas, (1998), Tymchuk (1981), and Woody (1990). Nine of the secondary practice-based models have been selected for brief review in this section (Garcia, et al.; Haas & Malouf; Hansen & Goldberg; Koocher & Keith-Spiegel, Mattison; Stadler; Tarvydas; Tymchuk; Woody). These nine models were selected based on frequent references within professional counseling literature, and because they were presented for broad clinical application.

Tymchuk: Guidelines and process for ethical decision making. Tymchuk (1981) offered a two-part model with multicultural underpinnings. The first part includes guidelines available to counselors from culture, government, and the profession. Guidelines from the profession comprise moral values, laws, codes of ethics, and

institutional policies. The second part of Tymchuk's model deals with the processes of decision making such as evaluating the situation, treatment direction and available options, reviewing concerns with clients and colleagues, and implementing of the selected decision.

Stadler: Clarifying controversial ethics. Stadler's (1986) model for ethical decision making offered a step-by-step process that is anchored in moral principles and moral reasoning. The first step in this model calls for an identification of competing moral principles. The second step involves "implementing a moral reasoning strategy" (p 5). There are four phases to this second step, (a) gathering information pertinent to legal or professional guidelines, (b) assessing any circumstance(s) unique to the particular case such as subpoenas or client competence, (c) prioritizing relevant moral principles, and (d) consulting with peers for challenge and/or support. The third step involves preparing for action and includes additional sub-steps to further identify, challenge and evaluate possible actions. Taking action is the final step, which concludes with a process of evaluation and reflection.

Woody: Decision bases for resolving ethical concerns. Woody (1990) offered a model encouraging therapists to draw upon what she calls "decision bases" (p. 135) for working through ethical difficulties. The decision bases are (a) ethical theories; (b) professional ethics codes; (c) personality theory; (d) social context; and (e) personal characteristics and/or professional identity. Ethical theory decision base encompasses both the intuitive and critical levels of thinking. The professional codes of ethics decision base addresses the full range of rule or principle ethics considerations.

Woody pointed out that theoretical orientation and the consequent premises about human nature and mental health are often drawn from to inform the decision-making process. The social context decision base includes social values, legal concerns, and organizational environment. In her discussion of personal characteristics and/or professional identity, Woody argued the "therapist is present as a person as well as an expert" (p. 143) throughout the clinical process and encouraged therapists to be conscious of their individual personal and professional identity.

Haas and Malouf: A framework for ethical decision making. Haas and Malouf (1995) divided the ethical decision-making process into two phases. According to Haas and Malouf, their model is not intended to be a system to be rigorously followed, but an attempt to "make explicit what should 'naturally' occur" (p. 7) in the course of the ethical decision-making process. The first phase of the Haas and Malouf model involves information gathering that includes identification of the problem, stake-holders, and relevant standards. The second phase is the actual process of decision making. The authors have anchored their framework in three basic principles: (a) autonomy, (b) professional adherence to established professional standards and social expectations or the principle of responsibility, and (c) an understanding that professionals are not self-serving in the decision-making process.

The steps in the model follow a decision tree format. The path depends on the answers given to questions concerning (a) relevance and reason for adhering to or deviating from professional standards, (b) potential for satisfaction on the part of affected individuals, and (c) probability of realistic ethical resolution. Haas and

Malouf (1995) concluded the presentation of their framework with some comments concerning the limits of such frameworks, including the reality that all such frameworks are by nature very general and idealistic.

Koocher and Keith-Spiegel: A suggested ethical decision-making process. Koocher and Keith-Spiegel (1998) adapted the work of Tymchuk (1981) and Haas and Malouf (1995) to form their nine-step procedure for ethical decision making. Step one involves determining the recognition of the ethical concern. Step two requires reviewing professional guidelines relevant to the problem under consideration. Step three requires counselors to evaluate their prejudices and attitudes that might interfere with objective reasoning. Step four encourages consultation with reliable colleagues. Step five involves evaluation of all potentially affected individuals and organizations. The final four steps involve generating action options, listing probable consequences of each action, selecting an action, and implementation of the action. Koocher and Keith-Spiegel pointed out it is in the implementation phase that the decision-making process is easily derailed.

Tarvydas: The integrative decision-making model of ethical behavior. According to Tarvydas (1998), "the integrative decision-making model of ethical behavior integrates the most prominent principle and virtue aspects of several decision-making approaches and introduces some contextual considerations into the process" (p. 146). Tarvydas built this model on the works of Rest (1984), Kitchener (1984b), and the four-level model presented by Tarvydas and Cottone in 1991. The Tarvydas model is presented in four stages with each containing several components or steps. The first

stage encourages counselors to develop ethical sensitivity, reflect on the potential dilemma, identify major stakeholders, and gather relevant facts. The second stage involves referring to professional standards and regulations, including employer policies, generating potential solutions, considering consequences for each possible action, consultation, and finally selecting a course of action. The third stage requires counselors to engage in reflection of personal values and contextual influences as a means of measuring moral and nonmoral values impacting the decision-making process. The fourth stage involves planning and implementing the selected course of action.

Tarvydas (1998) suggested four themes or attitudes as foundational to these four stages and argued that "by adopting these background attitudes of balance, reflection, context, and collaboration, counselors engage in a more thorough process that will help preserve the integrity and dignity of all parties" (p. 149). Balance refers to weighing all of the issues, individuals, and viewpoints impacting the decision-making process. Reflection involves counselor self-awareness of values and skills. Context encompasses therapeutic relationship dynamics, organizational structures, and social setting. Collaboration refers to including all parties, particularly the client, in decision-making.

Hansen and Goldberg: A matrix of considerations for navigating the nuances. Hansen and Goldberg (1999) presented seven categories to guide counselors in the decision-making process. The categories are (a) moral principles and personal values, (b) clinical and cultural factors, (c) professional codes of ethics, (d) agency or

employer policies, (e) laws, (f) rules and regulations related to laws such as application of state licensure laws, and (g) case law or common law that develops over time within the court system. Hansen and Goldberg highlighted two aspects of their model as relatively unique. First they pointed out that although moral principles and legal concerns have been included in some models, "rarely are clinical and cultural considerations addressed" (p. 495) within models on ethical decision making. Secondly, they presented their model as a matrix intended to be used as "a web of considerations" (p. 501) as opposed to the more traditional hierarchical model format.

Mattison: The person in the process of ethical decision making. The premise of Mattison's (2000) model is that counselor values inevitably influence the decision-making process. The model calls for counselors to engage in "reflective self-awareness" (p. 201). The seven-step model is presented in a one-dimensional pyramid bordered on each side by the phrase "value system/preferences of the decision maker" (p. 210). The steps in the model include consideration of client background information, separating practice considerations and ethical components, identifying value tensions, identifying principles in professional standards, assessing priorities, and coming to a resolution. After the selected action has been implemented, Mattison suggested continued reflection concerning the influence of counselor values on decision-making.

Garcia, et al.: Transcultural integrative model. The transcultural integrative ethical decision-making model put forward by Garcia et al. (2003) overtly speaks to issues of diversity in the ethical decision-making process. Garcia et al. presented a

four-step model with many sub-steps in each step. Each sub-step delineates both the more traditional approaches to ethical decision-making and then describes the transcultural alternative. For example, in consultation with supervisors the general principle is to "consult with supervisors and other knowledgeable professionals" (p. 273). The transcultural principle is to "consult with supervisors and professionals who have pertinent multicultural expertise" (p. 273). Table 6 summarizes the steps proposed in the transcultural integrative model.

Table 6

Transcultural Integrative Model for Ethical Decision Making in Counseling

Step	Task
1	Interpreting the Situation Through Awareness and Fact Finding: Sensitivity and awareness, reflect and analyze, determine major stakeholders
2	Formulating an Ethical Decision: Review dilemma, determine relevant standards/laws, generate courses of action, consider potential consequences, consult, select best action
3	Weighing Competing, Nonmoral Values and Affirming the Course of Action: Reflection on personal bias, consider contextual influences on value selection
4	Planning and Executing the Selected Course of Action: Develop reasonable action plan, anticipate personal and contextual barriers, implement and evaluate

Note: Adapted from Table 2 in A transcultural Integrative Model for Ethical Decision Making in Counseling by J. G. Garcia, B. Cartwright, S. M. Winston, and B. Borzuchowska, 2003, *Journal of Counseling & Development*, 81, p. 81. Copyright 2003 by the American Counseling Association.

Research Related to Ethical Decision-Making Models

Only two research studies were found that investigated the ideas developed within theory-based models. No studies were found related to practice-based models. Cottone (2001) found a lack of ethical decision-making models addressing social influences on the ethical decision-making process and reported finding only one research study (Cottone, Tarvydas, & House, 1994) that investigated the issues of social influence on ethical decision making. Burkemper (2002) explored preferred ethical decision-making practices of marriage and family therapists.

Cottone et al. (1994) worked with graduated students to evaluate the "effect of relationships on ethical decision making" (p. 59). They found that when graduate students were asked to reconsider a decision, interpersonal relationships influenced ethical judgment and the decision-making process. According to Cottone et al., the results support their belief that ethical decision making is "to some degree, an interpersonal matter and not simply a matter of an individual's internal moral standards" (p. 63).

The Burkemper (2002) study utilized a survey format to investigate therapist response to ethical decision making using two case scenarios, of which one concerned child abuse and the other HIV. The study sought to understand what components of the two levels of decision making outlined by Kitchener (1984b) were used in each of these two scenarios. In both scenarios the participants reported nonmaleficence (do no harm) as primary in their considerations. However, the results indicated in the child abuse situation participants ranked legal considerations higher then in the HIV

scenario. The personal or intuitive-level responses were ranked higher in the HIV scenario then in the child abuse situation.

Common Components in Ethical Decision-Making Models

There are a number of components found in the ethical decision-making models reviewed in this chapter. A summary of those common components is offered in this section. Discussion of the common components is limited to material directly related to the author's presentation of their models. Tables 7 through 11 list the common components in ethical decision-making models reviewed in this chapter. For purposes of clarity and discussion the components are broken into five categorical tables: counselor makeup, working with the client, information gathering, action steps, and post decision reflection. The first seven columns in each of the tables correspond with the three primary theory-based models of Rest (1984, 1994), Kitchener (1984b, 2000), and the feminist model of Hill et al. (1995) and the four primary practice-based models of Forester-Miller and Davis (1996), Remley and Herlihy (2005), Welfel (2006), and Corey et al. (2007). The final column is titled "other" and indicates the presence of the particular component in at least one of the secondary theory-based and/or practice-based models reviewed in this chapter.

Throughout the common component tables three different symbols are used to designate which models contained particular components and the emphasis placed on the component in each of the models. An X symbol indicates the author(s) of that respective model have placed major emphasis on the corresponding component within

the presentation of their model. A ⊗ symbol indicates the component is present in the corresponding model but is only a minor factor as if tucked into the author's discussion of the model as a less dominate consideration. A blank space indicates no mention of the component was made in presenting the corresponding model.

Counselor Makeup

A number of authors have discussed counselor makeup in relation to ethical decision making and the consequent influence counselor character, values, morality, world view, and/or inherent virtue has on the ethical decision-making process (Betan, 1997; Cohen & Cohen, 1999; Corey et al., 2007; Garcia et al., 2003; Hansen & Goldberg, 1999; Hill et al., 1995; Jordan & Meara, 1990; Kitchener, 2000; Mattison, 2000; Meara et al., 1996; Remley & Herlihy, 2005; Rest, 1984, 1994; Stadler, 1986). Betan and Mattison argued that counselor makeup and interactions intricately influence the ethical decision-making process. Corey et al. cautioned counselors-in-training concerning the influence their feelings and interpretations have on ethical decisions. Remley and Herlihy proposed that ethical professional practice emerges from within the professional, with counselor intentionality and courage being critical to the enactment of ethical counseling.

In 1995 Hill et al. argued "the person of the therapist has been strikingly absent from the public discourse on ethical decision making" (p. 24) and argued this omission had left a significant gap in the guidance offered to counselors struggling with ethical decisions. Hill et al. included in the person of the therapist issues of

countertransference, feelings about the client and/or ordinary professional matters such as consultation and regulations, and personal disposition. The authors suggested that although counselor orientation may not change the actual outcome, it influences the process of decision making and implementation.

Several authors (Haas, Malouf, & Mayerson, 1988; Kimmel, 1991; Woody, 1990) have addressed some specific counselor characteristics influencing the ethical decision-making process. Kimmel indicated that when mental health professionals pursue research interests, "ethical decisions and moral judgments may be affected by the investigator's cultural and personal characteristics, interests, and values" (p. 786). Haas et al., found that although mental health professionals are similar in many respects, they "differ in choice of response to certain ethical dilemmas" (p. 35) according to theoretical orientation, gender, and years of experience factors. Woody noted that the theoretical framework out of which counselors choose to work influences the ethical decision-making process. Table 7 lists the common components in ethical decision-making models pertinent to counselor makeup.

Virtue and values. The virtue and values component addresses character qualities or virtues counselors bring to professional life and/or how they live out moral life whether consciously or unconsciously. Kitchener (2000) noted discussion of counselor character under the category of virtue ethics is a relatively recent addition to ethical decision-making literature within the mental health professions.

Table 7

Counselor Makeup: Common Components of Ethical Decision-Making Models

	Primary Theory Based			Primary Practice Based				Other
Component	R	K	F	F/D	R/H	W	C's[a]	
Virtue and Values	X	(x)	X		(x)			✔
Moral Sensitivity	X	(x)	(x)		(x)	X		✔
Contextual Sensitivity			X		(x)			✔

[a] R = Rest (1984, 1994), K = Kitchener (1984b, 2000), F = Feminist (Hill et al., 1995), F/D = Forester-Miller and Davis (1996), R/H = Remley and Herlihy (2005), W = Welfel (2006), C's = Corey et al. (2007),

X = Full component/major emphasis, (x) = tucked in discussion, ✔ = discussed

Of the primary ethical decision-making models reviewed in this chapter, only the models of Rest (1984, 1994) and the feminist model of Hill et al. (1995) place major emphasis on the concepts of virtue and/or values. The primary models of Kitchener (1984b, 2000) and Remley and Herlihy (2005) include some discussion related to counselor virtue and/or values tucked in their ethical decision-making steps as indicated in Table 7. Corey et al.(2007) and Welfel (2006) each offer only a couple of incidental statements referencing counselor values within the presentation of their ethical decision-making models and thus this component is blank in Table 7. No mention of virtue or values is found in the Forester-Miller and Davis model (1996).

Within the secondary models, there are a number of references to counselor virtue and/or values. The Cohen and Cohen (1999) model places major emphasis on counselor virtue. Betan (1997), Tymchuk (1981), Woody (1990), Mattison (2000), and Garcia et al. (2003) all indicate counselor values influence the decision-making process.

Moral sensitivity. This component addresses counselor *ability to* recognize, understand, clarify, and implement a moral response to ethical concerns within the clinical setting. Moral sensitivity is the first component of the Rest (1984, 1994) model and is defined by Rest as

> the awareness of how our actions affect other people. It involves being aware of different possible lines of action and how each line of action could affect the parties concerned. It involves imaginatively constructing possible scenarios, and knowing cause-consequence chains of events in the real world; it involves empathy and role-taking skills. (1994, p. 23)

The first step in the Welfel (2006) model is "develop ethical sensitivity" (p. 24). The models of Kitchener (1984b, 2000), Hill et al. (1995), and Remley and Herlihy (2005) each tucked discussion related to ethical sensitivity within the steps or elements of their models. No mention of moral or ethical sensitivity is found in the Forester-Miller and Davis model (1996). Within the secondary models, only the works of Hare (1981) and Tarvydas (1998) discussed the concept of ethical sensitivity.

Kitchener (1984b, 2000), building on the work of Hare (1981), included the essence of this component within her discussion of the intuitive level. Other authors referred to the intuitive level of ethical decision making and agreed with Kitchener that intuition alone is not sufficient for complex ethical difficulties (Hill et al., 1995; Welfel, 2006).

Some have cautioned that intuition may at times be misguided (Hare, 1981; Hill et al., 1995; Welfel, 2006). Hill et al. and others (Remley & Herlihy, 2005) have argued moral sensitivity, more currently referred to as ethical sensitivity (Welfel), requires counselors to attend to their feelings.

Contextual Sensitivity. The contextual sensitivity component addresses a broad range of concerns emerging within the environmental framework of the therapeutic relationship. Context includes consideration of "age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, and socioeconomic status" (ACA, 1995, Section A.2.a.) of the counselor, client, or other affected parties. The contextual sensitivity component is emphasized in the primary theory-based model of Hill et al. (1995). Remley and Herlihy (2005) offered significant discussion

concerning contextual sensitivity within the introduction to their model. There is no discussion of contextual sensitivity within the presentation of the other primary models reviewed in this chapter. Discussion of this component is present in the secondary model presentations of the social constructivism model of Cottone (2001, 2004), the virtuous therapist model of Cohen and Cohen (1999), the hermeneutic model of Betan (1997), the models of Woody (1990), Hansen and Goldberg (1999), and the transcultural integrative model of Garcia et al. (2003).

Working with the Client

The concept of working with the client throughout the ethical decision-making process as presented in the feminist model of Hill et al. (1995) is grounded in the feminist belief that, when clinically appropriate, the power differential between counselor and client should be equalized as much as possible. Corey et al. (2007) and Remley and Herlihy (2005) indicated that Hill et al. influenced their models. The introduction to the Corey et al. model presented the notion that counselors make decisions with clients and not for clients. In presenting the steps of their model Corey et al. included direct reference to working with the client in three of the eight steps of their model. Remley and Herlihy designated one of their 6 decision-making elements to involving clients in the decision-making process as both a client-empowering intervention and a culturally appropriate process. Table 8 indicates that the feminist model of Hill et al., the Corey et al. model, and the Remley and Herlihy model all contain full steps or major emphasis on working with the client. None of the other

presentations of the primary or secondary models contained discussion on working with the client.

Table 8

Working with the Client: Common Components of Ethical Decision-Making Models

	Primary Theory Based			Primary Practice Based				Other
Component	R	K	F	F/D	R/H	W	C's[a]	
Working with Client			X		X		X	

[a] R = Rest (1984, 1994), K = Kitchener (1984b, 2000), F = Feminist (Hill et al., 1995), F/D = Forester-Miller and Davis (1996), R/H = Remley and Herlihy (2005), W = Welfel (2006), C's = Corey et al. (2007),

X = Full component/major emphasis, (x) = tucked in discussion, ✔ = discussed

Information Gathering

The common components in the information-gathering category are to identify and clarify, consider principles, professional regulations, consult literature, consult colleagues, and system dynamics. The information gathering components are listed in Table 9.

Table 9

Information Gathering: Common Components of Ethical Decision-Making Models

	Primary Theory Based			Primary Practice Based				Other
Component	R	K	F	F/D	R/H	W	C's[a]	
Identify and/or Clarify			X	X	X	X	X	✔
Consider Principles		X	(x)	X	X	X	X	✔
Professional Regulations		X	(x)	X	X	X	X	✔
Consult Literature				(x)	(x)	X		✔
Consult Colleagues			(x)	(x)	X	X	X	✔
System Dynamics	(x)				(x)			✔

[a] R = Rest (1984, 1994), K = Kitchener (1984b, 2000), F = Feminist (Hill et al., 1995), F/D = Forester-Miller and Davis (1996), R/H = Remley and Herlihy (2005), W = Welfel (2006), C's = Corey et al. (2007),

X = Full component/major emphasis, (x) = tucked in discussion, ✔ = discussed

Identify and/or clarify. The feminist model presented by Hill at el. (1995) is the only major theory-based model to overtly address the need to define and/or clarify the ethical concern. All of the practice-based models explicitly address the need to define and/or clarify the particular ethical concern. There are a number of secondary models reviewed in this chapter (Cottone, 2001, 2004; Cohen & Cohen, 1999; Haas & Malouf, 1995; Garcia et al., 2003) that also address the contents of this component.

Consider principles. The considering principles component refers to the moral principles of autonomy, nonmaleficence, beneficence, justice, and fidelity presented to the mental health professions by Kitchener (1984b), as well as veracity, which was added by Corey et al. (2007) and Remley and Herlihy (2005). It should also be noted here that Garcia et al. (2003) argued for consideration of the principle of tolerance within the ethical decision-making process for professional counselors. All of the major models reviewed in this chapter, with the exception of Rest (1984, 1994) and Hill et al. (1995), emphasize consideration of moral principles. Many of the secondary models also indicate that consideration of moral principles is a significant step in the ethical decision-making process (Betan, 1997; Garcia et al.; Haas & Malouf, 1995; Hansen & Goldberg, 1999; Stadler, 1986). Although the feminist model of Hill et al. does not emphasize consideration of principles, the authors included discussion of principles in their model but indicated caution is necessary in the use of moral principles. Hill et al. argued that in consulting moral principles counselors need to take heed because interpretation of moral principles may be biased by one's "context of power" (p. 21), which is related to gender, racial identity, and socioeconomic status.

Professional Regulations. The professional regulations component includes ethics codes, legal regulations, and case law. Within the major models reviewed in this chapter Kitchener (1984b, 2000), Forester-Miller and Davis (1996), Remley and Herlihy (2005), and Welfel (2006), and Corey et al. (2007) all specify consulting professional regulations as a major concern in the ethical decision-making process. Rest (1984, 1994) makes no mention of professional regulations. Hill et al. (1995) tucked reference to consultation of professional regulations within their discussion of identification and definition of the problem. A number of the secondary models reviewed in this chapter (Cohen & Cohen, 1999; Garcia et al., 2003; Haas & Malouf, 1995; Hansen & Goldberg, 1999; Mattison, 2000; Stadler, 1986; Tymchuk, 1981; Woody, 1990) referenced the need to consult professional regulations.

Consult literature. Consult relevant ethics literature is referred to in four of the twenty models reviewed in this chapter. The Welfel (2006) model is the only model presentation reviewed in this chapter to devote significant discussion to this component. Forester-Miller and Davis (1996) and Remley and Herlihy (2005) tucked encouragement to review professional literature within their discussions of identification and clarification of the problem. Within the secondary practice-based models, Haas and Malouf (1995) are the only authors who encouraged consulting the literature in presenting their models.

According to Welfel (2006), reading relevant literature gives counselors access to expert perspectives, provides a potentially significant resource for counselors who feel vulnerable and/or isolated in particular decision-making situations, and assists

counselors in developing a substantive rationale for their decisions and consequent interventions. Welfel argued knowledge of relevant "literature is a necessity, not a luxury, for a competent counselor" (p. 31), and because professional literature is accessible through electronic communication, lacking knowledge of relevant literature could be grounds for judging counselors as incompetent. Using literature as a resource, according to Welfel, can also diminish the sense of isolation when counselors face complex and difficult ethical decisions.

Consult colleagues. Included in this component are the activities of ongoing supervision, case-specific consultation, networking with peers, and using resources available through professional organizations. Rest (1984, 1994) and Kitchener (1984b, 2000) did not speak about consultation in presenting their models. Although Hill et al. (1995) incorporated consultation within several steps of their model, they also cautioned counselors to be aware of the influence "the consultant's values, conceptualizations of therapy, and relationship to the questioner are likely to have" (p. 27) on the decision-making process. The remaining primary theory and practice-based models reviewed in this chapter (Corey et al., 2007; Forester-Miller & Davis, 1996; Remley & Herlihy, 2005; Welfel, 2006) included consultation either as a full step within the process or emphasized the need for consultation as a part of several steps. Within the secondary models reviewed in this chapter, Cottone (2001, 2004), Tymchuk (1981), Haas and Malouf (1995), Stadler (1986), and Garcia et al. (2003) urged counselors to seek consultation during the ethical decision-making process. In

the social constructivism model of Cottone, consultation is the central pillar of the decision-making process.

System dynamics. The system dynamics component involves consideration of the organizational context in which the ethical difficulty emerges. None of the major models reviewed in this chapter offered significant discussion or emphasis on system dynamics. Rest (1984, 1994) indicated that for counselors who are "not sufficiently motivated . . . protecting one's organization" (p. 24) may replace other higher values. Remley and Herlihy (2005) included agency or institutional policies as a potential resource for counselors who are struggling with ethical concerns. Several of the secondary models reviewed in this chapter (Cottone, 2001, 2004; Garcia et al., 2003; Hansen & Goldberg, 1999; Stadler, 1986; Woody, 1990) made reference to consulting organizational policies. Woody suggested that it is critical for counselors to contemplate "the extent to which the setting - its structure, purpose, economics, policies, and role definition - impact on the professional's conduct of therapy" (p. 143) and, consequently, the ethical decision-making process. The secondary model presented by Hansen and Goldberg designated an entire element of their model to issues of organizational governance.

Action Steps

The common components within the action steps category are possible actions, consider outcomes, select actions, and implement actions. These components are summarized in Table 10.

Table 10

Action Steps: Common Components of Ethical Decision-Making Models

	Primary Theory Based			Primary Practice Based				Other
Component	R	K	F	F/D	R/H	W	C's [a]	
Possible Actions	(x)		X	X	X	(x)	X	✔
Consider Outcomes	(x)		X	X	X	X	X	✔
Select Action(s)	X		X	X	X	X	X	✔
Implement Action(s)	X		X	X	X	X	X	✔

[a] R = Rest (1984, 1994), K = Kitchener (1984b, 2000), F = Feminist (Hill et al., 1995), F/D = Forester-Miller and Davis (1996), R/H = Remley and Herlihy (2005), W = Welfel (2006), C's = Corey et al. (2007),

X = Full component/major emphasis, (x) = tucked in discussion, ✔ = discussed

Possible actions. The concept of generating options is included in most of the major models and several of the secondary models reviewed in this chapter. Hill et al. (1995), Forester-Miller and Davis (1996), Remley and Herlihy (2005), and Corey et al. (2007) all dedicated a full step or element to generation of possible actions. Rest (1984, 1994) tucked the concept of generating options within his moral sensitivity component, stating that moral sensitivity "involves being aware of different possible lines of action and how each action could affect the parties concerned" (p. 23). Welfel (2006) included listing potential available responses as part of identifying the dilemma. Kitchener (1984b, 2000) did not mention generating possible courses of action within the presentations of her model for ethical decision making. Within the secondary models reviewed for this chapter, Stadler (1986), Mattison (2000), and Garcia et al. (2003) make generating options a full step. Haas and Malouf (1995) emphasized the identification of possible actions within the information-gathering phase.

Various authors encouraged different methods of generating possible actions. A number of the authors encourage brainstorming (Corey et al., 2007; Forester-Miller & Davis, 1996; Haas and Malouf, 1995; Remley & Herlihy, 2005; Stadler, 1986) as a means to identify and generate possible courses of action to resolve ethical dilemmas. Rest (1984) encouraged "imaginatively constructing possible scenarios" (p. 23). Garcia et al. (2003) encouraged using the constructivism techniques of negotiating, consensualizing and arbitrating to identify culturally appropriate courses of action.

Forester-Miller and Davis (1996), Corey et al., and Remley and Herlihy suggested that consulting colleagues is often useful in generating possible options.

Consider outcomes. Considering outcomes and/or potential consequences of each possible action is closely related to both generating possible actions and selecting the best course of action within many ethical decision-making models. It is separated out here because a number of the models reviewed in this chapter placed significant emphasis on this task. Some models (Corey et al., 2007; Forester-Miller & Davis, 1996; Garcia et al., 2003; Hill et al., 1995; Remley & Herlihy, 2005; Stadler, 1996; Welfel, 2006) set the evaluation of possible or selected actions apart as a full step or element. Others bundled this and other tasks together to form multi-layered steps (Haas & Malouf, 1995; Mattison, 2000; Rest, 1984, 1994). Rest (1984, 1994) included this evaluation process of potential actions as part of moral sensitivity, stating that moral sensitivity includes "knowing cause-consequence chains of events in the real world" (p. 23). Forester-Miller and Davis, Corey et al., Welfel, and Remley and Herlihy encouraged consultation, understanding of potential consequences for all involved (including the counselor), and reflection as a part of evaluating possible actions. Hill et al. encouraged counselors to be involved in personal introspection as a means of evaluation and review.

Select Action(s). Selection of a course of action is a stand-alone step within some of the models (Corey et al., 2007; Garcia et al., 2003; Hill et al., 1995; Mattison, 2000; Rest, 1984, 1994). Rest (1984) described this step as judging "which line of action is more morally justifiable" (p. 24). Hill et al. and Corey et al. encouraged counselors to

involve clients in the process of selection. Hill et al. argued selecting an action includes determining if the selected action is a good emotional and rational fit for everyone including the counselor. Garcia et al. contended the "best ethical course of action is selected based on a rational analysis of the principles involved" (p. 271).

Other authors (Forester-Miller & Davis, 1996; Haas & Malouf, 1995; Remley & Herlihy, 2005; Stadler, 1986; Welfel, 2006) presented selecting a course of action as an intricate part of evaluating outcomes and/or the action of implementation. Forester-Miller and Davis encouraged counselors to select the action or mixture of actions that contain the greatest potential for resolving the identified concern(s). Welfel suggested counselors "deliberate alone" (p. 40) as they sort options and select what they believe to be the best, ethical action and develop a plan for implementing the action. Remley and Herlihy, as well as Stadler, also tied the selection process closely to development of a realistic plan of implementation. Haas and Malouf highlighted the need to evaluate whether or not the selected course of action might "present new ethical problems" (p. 16).

Implement Action(s). A number of models reviewed in this chapter designated implementation of the selected action as a separate step (Cohen & Cohen, 1999; Forester-Miller & Davis, 1996; Garcia et al., 2003; Hill et al., 1995; Rest, 1984, 1994; Stadler, 1986; Welfel, 2006). Although Corey et al. (2007) and Remley and Herlihy (2005) combine action selection and implementation, their presentations stress implementation is a significant component in the ethical decision-making process.

Haas and Malouf (1995) have included a few comments on implementation within the second section of their two-section model format.

Within ethical decision-making models, the concept of moral courage or character is mentioned a number of times in relation to implementation of the selected action. Rest entitled his implementation component "moral character" (p. 24) and pointed out that "psychological toughness and strong character do not guarantee adequacy in any of the other [three] components, but a certain amount of each is necessary to carry out a line of action" (p. 24). The theme of character and courage as necessary to implementation is present also in the models of Cohen and Cohen (1999), Forester-Miller and Davis (1996), and Remley and Herlihy (2005). Cohen and Cohen argued that virtuous counselors are willing to carry out what they believe to be the right moral action choice in spite of indications that doing so may mean incurring potentially significant difficulties. Forester-Miller and Davis, and Remley and Herlihy contended counselors need to develop strong character if they are to have the internal strength required to implement challenging decisions.

Stadler (1986) contended that, in the normal course of professional life, counselors will encounter situations in which nonmoral values will compete with moral values during the implementation step. Although Stadler did not encapsulate her cautions in terms of moral character, she did encourage counselors to consider and identify the "nonmoral considerations" (p. 8), such as apprehension about negative repercussions including, but not limited to, potential financial loss and/or the

judgments and scrutiny of others. Stadler suggested forming accountability relationships with other professionals to help counteract the pull of nonmoral values.

Continued evaluation (Hill et al., 1995), attending to one's internal process including the influence of values and power differential factors (Hill et al.; Remley & Herlihy, 2005; Welfel, 2006), informing all relevant and appropriate parties (Welfel), possessing clinical skill (Haas & Malouf, 1995), and considering contextual factors (Garcia et al., 2003; Hill et al.) are other notions that surface in the discussion of resolution of ethical dilemmas through implementation of a selected action. Hill et al. recommended continued evaluation because "it is not uncommon for the therapist's intervention to throw more light on the situation, which might then lead to redefinition of the problem, development of further solutions, and so forth" (p. 31). Hill et al. and Remley and Herlihy recommended counselors continue to attend to their feelings as the process of implementation unfolds. Welfel argued informing appropriate parties is necessary to implementation. According to Welfel, the appropriate parties include supervisor(s), the client, and other potentially relevant people. Haas and Malouf argued that executing the selected course of action well requires counselors have the capacity to be appropriately assertive and "the ability to communicate one's chosen action in noncondescending and humane terms" (p. 18).

Post-Decision Reflection

Only the models of Hill et al. (1995) and Welfel (2006) devoted an entire step to post-decision reflection. Corey et al. (2007), Remley and Herlihy (2005), and Stadler

(1986) recommended post-decision reflection as a means of learning and/or evaluation and tacked the concept of post-decision reflection onto the end of their discussions of action selection and implementation. Forester-Miller and Davis (1996) did not recommend post-decision reflection, but they did encourage counselors to follow up on the outcome(s), whenever possible, in order to assess the consequences and/or effectiveness of their action(s). Hill et al., Remley and Herlihy, and Stadler recommended attending to *moral traces*. According to Remley and Herlihy, counselors may experience "moral traces, which are lingering feelings of doubt, discomfort, or uncertainty that counselors may experience after they have resolved an ethical dilemma, particularly when expediency, politics, or self-interest have influenced the decision" (p. 14). Stadler noted that these feelings or moral traces naturally emerge when counselors engage in difficult ethical decision-making processes that have no clear right answer. Beauchamp and Childress (2001) indicated moral traces are "appropriate and even expected in a person of good moral character" (p. 406). A summary of the implementation component as presented in models of ethical decision making is offered in Table 11.

Table 11

Post Decision Reflection: Common Components of Ethical Decision-Making Models

	Primary Theory Based			Primary Practice Based				Other
Component	R	K	F	F/D	R/H	W	C's[a]	
Reflection			X	(x)	(x)	X	(x)	✔

[a] R = Rest (1984, 1994), K = Kitchener (1984b, 2000), F = Feminist (Hill et al., 1995), F/D = Forester-Miller and Davis (1996), R/H = Remley and Herlihy (2005), W = Welfel (2006), C's = Corey et al. (2007),

X = Full component/major emphasis, (x) = tucked in discussion, ✔ = discussed

Decision-Making Process Style: Linear or Nonlinear Model Process

Although the style and nature of the decision-making process within ethical decision-making models does not constitute a content component, many of the authors address this matter in presenting their models (Betan, 1997; Cohen & Cohen, 1999; Corey et al., 2007; Cottone, 2001, 2004; Garcia et al., 2003; Haas & Malouf, 1995; Hansen & Goldberg, 1999; Hill et al., 1995; Kitchener, 1984b, 2000; Remley & Herlihy, 2005; Rest, 1884, 1994) and/or critiquing other models (Betan; Hill et al., 1995; Remley & Herlihy, 2005). A brief discussion of the process style and nature of ethical decision-making models is important to this overview of the commonalties of ethical decision-making models.

The process styles presented within the primary theory-based models are an assortment of linear, accused of linearity, not intended to be linear, hierarchical, and interactive. Rest (1994) indicated that the four components of his model are not intended to outline a linear process but a complex interaction of four components that "comprise a *logical* analysis of what it takes to behave morally" (p. 24). Kitchener (1984b, 2000) described her model as "different levels of moral reasoning and that they are hierarchically related" (2000, p. 11). The feminist model presented by Hill et al. (1995) stresses an interactive and nonlinear decision-making process.

All but one presentation of the primary practice-based models addressed the issue of linear thinking in the ethical decision-making process directly or indirectly. Forester-Miller and Davis (1996) do not comment on linearity in presenting their model. Corey et al. (2007) and Remley and Herlihy (2005) argued that ethical decision making is not a linear process and the consequent models they presented were not intended to be followed in a step-by-step fashion. Welfel (2006) did not directly address linearity within the presentation of her model but indicated several steps or portions of steps needed to be attended to throughout the decision-making process. Remley and Herlihy indicate that their selection of "elements" rather than steps encourages the feminist idea of processing in a nonlinear manner.

A number of the theory-based and practiced-based secondary ethical decision-making models discussed in this review addressed the issue of process style. Cottone's (2001; 2004) constructivism model presented ethical decision making as an interactive process involving negotiating, consensualizing, and arbitrating. Cohen and Cohen

(1999) presented an interactive yet systematic set of steps intended to outline a dynamic process. Betan (1997) asserted that his hermeneutic model is an interpretive-interactive process of ethical decision making anchored in the context of therapeutic relationships. Hansen and Goldberg (1999) intentionally presented their model as a "matrix or web" (p. 501) and contended resolving ethical difficulties "cannot be neatly placed in decision trees, like diagnostic determinations" (p. 501). According to Garcia et al. (2003), their transcultural integrative model "involves a step by step linear method" (p. 275).

BOUNDARIES OF COMPETENCE

General Overview

Significance

Competence is foundational to the life of mental health professionals and critical to the vitality of their professions (Herlihy & Corey, 1996; Haas & Malouf, 1995; Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Remley & Herlihy, 2001). Swenson (1997) and Remley and Herlihy pointed out that competence includes both ethical and legal considerations. According to Swanson, mental health professionals are legally and ethically responsible to "be fully trained, keep up-to-date, and be good at what they do. Otherwise they should stop doing it" (p. 64). Abeles (1994) and Remley and Herlihy argue that the ideas encapsulated within professional competence are directly related to the profession's commitment to client welfare and maintaining public trust.

According to Lakin (1988) and Remley and Herlihy (2001), competence is linked to ethical or unethical behavior that has the potential to assist or injure clients. Kitchener (2000) argued that incompetent practice can "lead to substantial harm" (p. 154). Berger (1982), Pope and Vasquez (1991), and Remley and Herlihy pointed out that competence is fundamental to clinical relationship and to client rights because counseling requires the client to present in the therapeutic relationship with self-disclosure, trust, vulnerability, and hope for resolution and healing around life's difficulties. Herlihy and Corey (1996) contended that trust is essential to the therapeutic relationship and must be honored with competent services.

Meara et al. (1996) argued that it is a consistent record of competence that allows a profession to maintain public trust. Abeles (1994) stated, "Nowhere is the issue of competence more salient than when it involves physical, emotional, legal, and spiritual well-being . . . . Society absolutely insists that those who provide health services be competent" (p. 275). According to Remley and Herlihy (2001), many lawsuits filed by clients against mental health professionals allege harm due to competence issues. Calfee (1997) reported boundary of competence complaints as common among those who treat addictions. Meara et al. (1996) tied competence and virtue together when they argued that the "primary goals of professionals are to be competent and to contribute to the common good" (p. 8).

Boundaries of competence concerns often fall into the category of ethical dilemmas (Van Hoose & Kottler, 1988). According to Van Hoose and Kottler, therapists repeatedly find themselves working outside their area(s) of competence

because every client brings distinctly different concerns and personal dynamics to the treatment process. Van Hoose and Kottler further pointed out that

> each time a therapist is confronted with a problem for which he [or she] is ill prepared, untrained, or inexperienced, he [or she] faces an ethical dilemma: Should he [or she] attempt to deal with the problem and see whether he [or she] can help without the preferred skills, or should he [or she] refer the client to someone more capable? Certainly, the therapist would much prefer to deal with the problem . . . if that is at all possible. One of the ways in which therapists continue to grow and learn is by encountering and mastering new difficulties . . . The ethical conflict arises, however, when one realizes that attempts to experiment with competencies in which he [or she] is not yet proficient, or will never truly master, can jeopardize a client's well-being. (p. 124)

Parameters and Definition

Codes of ethics and the literature refer to competence in two basic ways. The first area of competence concerns whether counselors are practicing within or beyond their acquired knowledge, skill, or experience level (Van Hoose & Kottler, 1988; Welfel, 2002) and is referred to as boundaries of competence. The second relates to the "impaired therapist" (Herlihy & Corey, 1996, p. 218) or "sick doctor" (Koocher & Keith-Spiegel, 1998, p. 68).

Both of these areas of competence are critical to understanding competent ethical practice. It is the ethical decision-making process in relation to the first area of competence, known as "boundaries of competence," that was the focus of this study. Discussion of counselor competence in this review is limited to considerations around the counselor's competence in relation to knowledge, skill, and experience. However, before proceeding with a discussion of boundaries of competence, the following short

paragraph offers a brief overview of the competency issues related to impaired counselor competency issues.

Kitchener (2000) indicated that counselors who find themselves in circumstances that may impair clinical judgment or interaction need to assess their level of true functional professional competence. According to Kitchener, Koocher and Keith-Spiegel (1998), and Pope and Vasquez (1991), in some cases counselors have placed themselves in these circumstances (e.g. drug abuse) but in other cases, life circumstances have evolved (e.g. personal stressors or professional burnout) that may diminish service provision on the part of the counselor. When personal difficulties intrude upon professional performance the situation can become harmful to the client (Kitchener, Koocher & Keith-Spiegel) and may eventually be dangerous to the public (Kitchener).

Competence is Difficult to Define

Because competence in relation to the practice of professional counseling is complex, it is difficult to define (Herlihy & Corey, 1996; Haas & Malouf, 1995; Pope & Vasquez, 1991; Rinas & Clyne-Jackson, 1988; Welfel, 2002). According to Koocher and Keith-Spiegel (1998), coming to a "consensus on a definition of competence . . . has been elusive" (p. 55). Rinas and Clyne-Jackson noted that there is significant "variability among and within different disciplines regarding" (p. 22) the skills, knowledge, and training needed to be competent in addressing therapeutic issues and argued that competence is "difficult to define on anything but an abstract

level" (p. 22). Herlihy and Corey pointed out that a specific and all-inclusive definition of competence is difficult to develop because counselors work with a "wide spectrum of clients and client concerns in very diverse settings that require different skills and competencies" (p. 217).

Kitchener (2000) discussed the difficulty in determining a precise definition of counselor competence in the following paragraph.

> The topic of competence can sometimes be overwhelming. Unlike many of the other ethical issues . . . there is an aspect of relativity that makes competence difficult to pin down. Questions such as the following frequently arise: Competent in comparison with whom? Competent by what standards? What exactly is a reasonable person standard? How up-to date should a professional's knowledge be? The standards are always stretching because the psychological knowledge base is always growing . . . Sometimes even competent [professionals] with deep personal integrity and high standards of responsibility cannot remain on top of the rapid expansion of knowledge even in their own areas of expertise . . . . Sometimes it is difficult to tell where incompetence or impairment begins and reasonable mistakes leave off . . . . Issues of responsibility are some of the most difficult with which to deal . . . because our work affects the lives of other humans. At the same time, we cannot be held to superhuman standards that never allow for an error in judgment. (p. 184)

There is, however, in the ethical codes (AAMFT, 2001; ACA, 2005; AMHCA, 2000; APA, 2002; CRCC, 2002; NASW, 1999; NBCC, 2005; NCDA, 2003) and the literature some consensus on the basic components included under the general rubric of competent professional counselor. This generally agreed upon rubric includes knowledge, skill attainment, supervised experience, self-awareness based in a commitment to ethical conduct, and pursuit of continuing education for professional growth (Anderson, 1996; Corey et al., 2007; Van Hoose & Kottler, 1988; Welfel, 2002). According to Remley and Herlihy (2001), competence as delineated in the *ACA Code of Ethics* (2005) is based on "education, training, supervised experience, state

and national professional credentials, and appropriate professional experience" (Standard C.2.a.).

Incompetence is Easier to Define than Competence

According to Kitchener (2000), competence may be "easier to identify in its absence than it is to clearly specify what a proficient level of practical . . . expertise involves" (p. 155). Van Hoose and Kottler (1988) define the incompetent therapist as "one who lacks the skill, ability, or qualifications to carry out a therapeutic task responsibly and effectively" (p. 108). Haas and Malouf (1995) believe it can be understood from the various codes of ethics that counselors who violate ethical standards "can be said to have acted in an incompetent manner" (p. 22).

Kitchener (2000), in discussing competence and incompetence, references the legal concept known as *standard of care.* According to Kitchener, "competence is often equated with practicing at or above the customary standard of care" (p. 155). Incompetence "is defined as practicing below the level of other reasonable psychologists with similar training and a similar theoretical orientation" (Kitchener, p. 158). Various professional groups have made efforts to define and regulate competence and incompetence through such avenues as ethical codes and licensing and certification boards. According to Koocher and Keith-Spiegel (1998), thus far no system has been able to effectively identify and execute penalties against those reported to be incompetent.

In addressing the issues of competence and incompetence, Haley, in his 1980 satire concerning methods therapists may or do engage in to disguise incompetence, suggested several strategies for practicing therapy when lacking in knowledge about the change process. These strategies include:

1. Limit your supervisor's knowledge of your work to your verbal self-report by refusing to tape or transcribe sessions and make sure to soundproof all walls, windows and doors in order to avoid casual listening at the door that could reveal your true intervention style.
2. Engage clients exclusively in long-term therapy and colleagues will forget whom they have referred and lack of change will go undiscovered.
3. Assist clients with avoiding issues of the present by exclusively encouraging exploration of the past with no application to present life.
4. In interactions with colleagues, presentations, and publications, avoid details of cases, making sure to use only summaries that include lots of psychobabble.
5. The most difficult problem will be dealing with dissatisfied customers but this can be managed by either blaming lack of progress on client resistance or explaining that they simply lack full understanding of all the remarkable changes that have been accomplished.

In discussing unethical and incompetent practice and referencing the above satire, Van Hoose and Kottler (1988) indicated that incompetent therapists might be at ease utilizing these guidelines.

According to Remley and Herlihy (2001), incompetence violates both legal and ethical standards as well as moral principles. They noted that the moral principle which most directly relates to incompetence is nonmaleficence or do no harm. They also argued that "incompetence is often a major factor in causing harm to clients" (p. 136) because lack of knowledge, skill, and capable application of both knowledge and skill can harm clients.

Koocher and Keith-Spiegel (1998) and Van Hoose and Kottler (1988) acknowledged there are real-life pressures that create an atmosphere for incompetence. Some of those pressures may come from a belief that being a professional means being able to treat all problems that are presented in the context of therapy. Koocher and Keith-Spiegel encouraged counselors to know that "not all therapists can work with all clients or all kinds of problems" (p. 55) and that referral due to lack of expertise in a specific area is not an indication of weakness. It has also been acknowledged that counselors also feel economic pressure to engage all clients who request their services (Koocher & Keith-Spiegel; Van Hoose & Kottler). Unfortunately, many clinicians may feel personal, social, or economic pressures to see whomever comes to their office" (Koocher & Keith-Spiegel, p. 55). Van Hoose and Kottler wrote the following strong rebuke to those who put financial gain ahead of client welfare.

> Most of the members of the helping professions are competent, honest, ethical, and dedicated. A few, however, do not feel compelled to live up to any external standard except the accumulation of financial resources and personal gain. They feel no responsibility to anyone but themselves and seemingly have no ethical conscience. Still worse, some of those who are engaging in unethical practices are not even aware of the damage they may be inflicting. (p. 110)

Measuring Competence

The question of how to declare, justify, and/or measure a counselor's competence has been addressed by several authors (Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Stein 1990). Stein noted that counselors are not like assembly-line workers who can be assessed by the number of items they produce in a given period of time. In contrast, counselors "work with that infinite variable known as the human being" (Stein, p. 39). Remley and Herlihy (2001) noted that because counseling is such a broad profession, there is a general understanding that no counselor is expected to be competent in every facet of potential professional service.

The most commonly agreed-upon measure of competence is anchored in legal standards and court rulings that set the benchmark for competence as the counselor doing his or her task(s) in a manner consistent with similarly trained and experienced peers (Kitchener, 2000; Lakin, 1991; Stein, 1990). According to Lakin, the courts have established that mental health professionals are obligated to practice in a manner "consistent with the way that a prudent professional in their own discipline or profession would" (p. 175). In a legal situation the counselor is competent if his or her colleagues affirm the "counselor's behavior conformed to at least a minimum standard of competence" (Stein, p. 39).

Competence and incompetence are not definitive set points of demarcation but ranges of adequacy measured on a continuum by comparison to other professionals (Welfel, 2002). Remley and Herlihy (2001) asserted that counselors are not either competence or incompetent in a black-and-white fashion, but rather, competency is a

"complex concept with many possible levels along a continuum" (p. 51). The continuum starts at a demonstrable minimal level with the counselor being considered adequate, moves to the mid-range seen as adequate or good, and for some, develops into exceptional (Koocher & Keith-Spiegel, 1998; Pope & Vasquez, 1991; Remley & Herlihy; Stein, 1990). Minimal levels of competence are generally evidenced through the completion of formal education, supervised experience, and credentialing or licensure (Pope & Vasquez).

Competence is not about perfection (Herlihy & Corey, 1996; Kitchener, 2000). Welfel (2002) pointed out levels of competence may vary with the day and the client, and argues that this is not only normal, it is acceptable within reasonable boundaries. Although Remley and Herlihy (2001) acknowledged that external forces of the profession, including licensure, require only the mandatory or basic level of competence; they contended counselors are always encouraged to strive for the ideal, aspirational or maximum level of competence in skills, knowledge, and professionalism.

Pope and Brown (1996) have suggested that counselors who have a high level of competence need both *intellectual* and *emotional* competence. Intellectual competence requires having the necessary knowledge and training, as well as the ability to conceptualize and plan treatment for the client population being served. Emotional competence involves the counselor's ability to manage the depth of information that emerges in the therapeutic process, the personal insight to identify personal biases and countertransference, and a capacity for self-care.

Self Assessment and Counselor Responsibility in Discerning Competence

A number of authors place the weight of discerning competence on the shoulders of individual practitioners (Berger, 1982; Claiborn, 1982; Haas & Malouf, 1995; Koocher & Keith-Spiegel, 1998; Kitchener, 2000; Rinas & Clyne-Jackson, 1988; Stein, 1990). According to Koocher & Keith-Spiegel, important elements involved in competence are knowing one's strengths, skills and abilities, and limitations. Van Hoose and Kottler (1988) observed that a significant factor in incompetence is the failure to recognize one's limitation. Pope and Vasquez (1991) point out that although there are times when clients tempt the therapist with unrealistic, idealized, and "sometimes virtually magical" (p. 51) expectations, counselors have a responsibility to know the limits of their competence and the therapeutic process and not encourage these expectations. Berger lists the responsibilities of the counselors as (a) being knowledgeable about standards of competence for specific services provided, (b) engaging in continuing education and supervision, (c) having a commitment to practice only within area(s) of competence, (d) being willing to suspend practice when impaired physically or psychologically, and (e) informing clients about limitations.

Stein (1990) summarizes the counselor's responsibilities in assessing and maintaining competence as follows:

> Clinical mental health counselors recognize the boundaries of their competence and the limitations of their techniques and only provide services, use techniques, or offer opinions as professionals that meet recognized standards. Throughout their careers, clinical mental health counselors maintain knowledge of professional information related to the services they render. (p. 40)

Welfel (2002) has given a few guidelines for professionals questioning how to evaluate their competence. First, she suggested professionals measure their competence by assessing their effectiveness in helping clients. As a point of emphasis Welfel stated, "Counseling that benefits the client and avoids unnecessary risk to him or her is the more fundamental measure of competence" (p. 49). Second, Welfel encouraged professionals to measure knowledge and skill levels against those in the field who have been recognized as competent in the area(s). Third, professionals need to assess their capacity to perform the needed tasks, not just their knowledge of the particular presenting problems or needed skills.

Competence as Presented in Ethics Codes

It has been said that all sections of each of the ethics codes, which pertain to mental health professionals, relate at least to some degree to the issues of competency (Haas & Malouf, 1995). However, each of the codes has set aside sections dedicated to addressing issues of competence. The five codes that apply most directly to the counselors in the study are the code of the ACA (2005), AMHCA (2000), NBCC (2005), NCDA (2003), and CRCC (2002). The codes outside of the discipline of counseling which are most frequently referenced in the literature concerning other mental health professionals and boundaries of competence are the APA (2002), NASW (1999), and AAMFT (2001). Boundaries of competence standards as presented in these eight codes are reviewed below.

Counselors. Table 12 lists the statements within the five codes most relevant to the counselors who participated in this study that speak directly to boundaries of competence concerns. All five of these codes clearly state that counselors are to recognize their limitations or boundaries of competence and are to practice within those limits. Additionally, each of these codes requires counselors to commit themselves to continued self-awareness and professional growth through continued education and/or supervision. Welfel (2002) pointed out that all codes "place the duty to monitor one's own competence and make necessary improvement directly in the hands of the individual professional" (p. 51).

In addressing the issues of professional responsibility, the ACA code (2005) is clear counselors are to attend to a number of specific concerns. Counselors are to commit themselves to skill and knowledge acquisition needed for working with diverse populations, and developing awareness of and sensitivity to the issues of diversity (Section C.2.a.). When developing a new specialty area, counselors are to protect clients from potential harm by obtaining adequate training and supervision when practicing within a new clinical domain (Section C.2.b.). Counselors are also to monitor both their own employment circumstances and the act of employing others, so that each counselor is working in positions that are within her or his boundaries of competence (Section C.2.c.). The code additionally requires counselors to continue evaluating their work through the use of consultation, peer supervision, and continuing education (Section C.2.d.e.f.).

Table 12

Boundaries of Competence Statements Found in Counselor Codes

Code	Boundaries of Competence Statements
ACA (2005)	Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors will demonstrate a commitment to gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. (Section C.2.a)
AMHCA (2000)	Mental health counselors recognize the boundaries of their particular competencies and the limitations of their expertise. Mental health counselors only provide those services and use only those techniques for which they are qualified by education, techniques or experience. Mental health counselors maintain knowledge of relevant scientific and professional information related to the services they render, and they recognize the need for on-going education. (Principle 7)
NBCC (2005)	Certified counselors recognize their limitations and provide services or use techniques for which they are qualified by training and/or supervision. Certified counselors recognize the need for and seek continuing education to assure competent services. (Section A.7)
NCDA (2003)	NCDA members recognize their limitations and provide services or only use techniques for which they are qualified by training and/or experience. Career counselors recognize the need, and seek continuing education, to assure competent services. (Section A.7)
CRCC (2002)	Rehabilitation counselors will practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Rehabilitation counselors will demonstrate a commitment to gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. Rehabilitation counselors will not misrepresent their role or competence to clients. (Section D.1.a)

In addition to being responsible to abide by professional codes of ethics, the counselors in this study are accountable to the law under which they are licensed. The state of Illinois law (2003) regulating professional counselors specifically states that one of the grounds for disciplining licensed professional counselors is professional incompetence when rendering counseling services. Although this study deals only with boundaries of competence as related to skill, knowledge, training and experience; it should be noted here that the Illinois State licensure law also clearly states that incompetence due to impairment through use of drugs, or physical and/or mental disability is also grounds for discipline.

Psychologists, Social Workers, and Marriage and Family Therapists. Table 13 cites statements found in the codes of ethics for members of the APA, NASW, and AAMFT. Each of these codes clearly calls their membership to practice within the limits of their boundaries of competence. Marriage and family therapists are required to maintain knowledge through continued education and/or supervision.

Table 13

Psychologists, Social Workers, and Marriage and Family Therapists Code Boundaries of Competence Statements

Code	Boundaries of Competence Statements
APA (2002)	Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. (Ethical Standards, 2.01)
NASW (1999)	Social workers provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience. (Ethical Standards Section 1.04.a.)
AAMT (2001)	Marriage and family therapists, do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies. (Principle 3.11.)
	Marriage and family therapists pursue knowledge of new developments and maintain competence in marriage and family therapy through education, training, or supervised experience. (Principle 3.1)

Fundamental Elements of Competent Practice

Knowledge and Basic Training

To say that one has knowledge competence "means being schooled in the history, theory, and research of your field and cognizant of the limits of current understanding" (Welfel, 2002, p. 47). Entry into the field of mental health as a practicing professional begins with completion of a graduate degree. A master's degree is the minimum standard degree for mental health counselors, social workers, and marriage and family therapists (Remley & Herlihy, 2001, Welfel). To practice as a psychologist one must obtain a doctoral-level degree (Koocher & Keith-Spiegel, 1998). Although the degree grants entry into the field, competence based on any degree is time-limited (Kitchener, 2000; Remley & Herlihy; Welfel). "Knowledge is the foundation of competence" (Kitchener, p. 156) and mental health professionals are not considered competent unless they are involved in ongoing knowledge acquisition that keeps them current in their area(s) of practice within the constantly evolving field of mental health theory and research (Kitchener; Koocher & Keith-Spiegel; Remley & Herlihy; Welfel).

The Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) set the standards related to course content and practical experience for degrees in counseling. The Counsel on Rehabilitation Education (CORE) set the standards for basic training in rehabilitation counseling (Remley & Herlihy, 2001). The CACREP (2001) standards require instruction in the following eight basic areas:

1. Professional identity, which includes history and philosophy of the counseling profession, an introduction to professional organizations that represent counseling, and instruction in professional ethics
2. Social and cultural diversity
3. Human growth and development
4. Career development
5. Helping relationship, which includes an introduction to counseling theory, essential interview and counseling skills, systems theories, and case conceptualization
6. Group work
7. Assessment, which includes instruction in test administration, standards and interpretation
8. Research methods.

Although standards have been set by CACREP and CORE, only a minority of counseling programs are accredited by one or both of these accrediting bodies (Remley & Herlihy, 2001). According to Remley and Herlihy, developing competency depends upon more than graduation from a program, whether it is accredited or not, because competency formed in master's training depends upon several interrelated factors. They indicated that factors beyond the scope of accreditation controls include motivation of individual students, quality of instruction, and quality of supervised experience.

Credentialing

Licensure. Licensing and specialty credentials are two forms of competence regulation and/or verification beyond the basic degree obtained in formal educational settings. Because it is established by state law, licensure is seen as the primary and most authoritative form of credentialing (Remley & Herlihy, 2001). Licensure is the primary legal modality for protecting the public from incompetent professionals (Corey et al., 2007; Remley & Herlihy). Remley and Herlihy argued that competence is a legal issue and that states hold counselors to expected standards of competence through state licensure laws and licensing boards.

There are limits to licensure. Licensure only addresses minimum levels of educational, knowledge, and experience attainment. A license cannot guarantee competent or ethical practice (Corey et al., 2003; Haas & Malouf, 1995; Pope & Vasquez, 1991), nor does it guarantee competence in all areas of practice, as licensing procedures are intended to cover only general practice standards (Corey et al.; Kitchener, 2000). Counselor licensure laws generally include continuing education standards requiring completion of continuing education hours for license renewal (Herlihy & Corey, 1996).

Certification. Certification offers a standard for general and specialty practice that certifies that counselors have specific training. Although some certifications are mandatory for practice in certain settings or with specified populations (e.g. public school counselors) (Remley & Herlihy, 2001), some certifications are voluntary and do "not exclude uncertified professionals from offering services in competition with

those who are fully certified to practice in an area" (Rinas & Clyne-Jackson, 1988, p. 41-42). There has not always been agreement in the professional community concerning the granting of specialty credentialing through certification and/or licensure as evidenced by discussion in the literature (Corey et al., 2007; Herlihy & Remley, 1995; Pate, 1995; Remley, 1995; Remley & Herlihy; Sweeney, 1995).

The NBCC offers a general certification that carries the title of National Certified Counselor (NCC). This is a voluntary credential and, according to Herlihy and Corey (1996), is a certification most counselors do not hold. The NBCC web site (2006) currently lists specialty certificates school (NCSC), clinical mental health (CCMHC), and addictions (MAC) counseling. There are a number of other more specific certifications available through a variety of organizations (Remley & Herlihy, 2001).

Skills, Abilities, and Experience

Competence in the area of skill means not only knowing the skill set, but also having the ability and understanding to select and/or create appropriate interventions using skills and discerning, when within a treatment regime, to apply a given skill (Kitchener, 2000; Pope & Vasquez, 1991; Remley & Herlihy, 2001; Welfel, 2002). Welfel contended that skill competence is about "performance not capacity" (Welfel, p. 49). According to Pope and Vasquez, a critical dimension of skill competence is knowing which interventions have some empirical evidence to support their effectiveness (Pope & Vasquez).

Haas and Malouf (1995) argued that competence includes more than knowledge gained in formal academia or in continuing education settings, as competency also involves having "procedural expertise" (p. 22). Kitchener maintained that skill competence requires professionals to stay current with research regarding "psychotherapy process and outcome" (Kitchener, 2000, p. 172). Kitchener contended skill competence also involves the physical and mental presence to apply knowledge. She noted that, at a given point in time, an "individual may have the knowledge and skill to perform a task but because of mental or psychical impairment they may be unable to use the knowledge and skills competently" (p. 157).

According to Remley and Herlihy (2001), being considered competent in a skill requires having significant supervised experience. During graduate training potential counselors are required to have supervised practicum and internship experiences (Remley & Herlihy). The state of Illinois moves counselors from the LPC or entry level of counselor license to the LCPC or clinical level of license based on accumulated supervised hours. According to the state of Illinois law (2003) regulating professional counselors, the counselor who holds a relevant master's degree is required to have "completed the equivalent of 2 years full-time satisfactory supervised employment or experience working as a clinical counselor under the direction of a qualified supervisor subsequent to the degree" to be licensed at the LCPC or second level of license (ILCS 107/45/b.3.A). Those who hold a relevant doctoral degree must have "completed the equivalent of 2 years full-time satisfactory supervised employment or experience working as a clinical counselor under the direction of a

qualified supervisor, at least one year of which is subsequent to the degree" to be licensed at the LCPC level (ILCS 107/45/b.3.B). Lichtenberg (1997), in his review of the literature on expertise in counseling, acknowledged experience is generally seen as a measure of skill attainment, expertise and competence for mental health providers. However, his review of the research led him to conclude that experience alone does not necessarily equate to clinical competence or expertise, particularly in the areas of clinical judgment and decision making.

The complexity of counseling means professionals cannot be skillful in all possible areas of client presentation (Corey et al., 2007; Welfel, 2002). Welfel argued that "counselors must limit their work to some subsample of problems and populations" (p. 48), and indicated that professionals and consumers should be skeptical of professionals who promote themselves as expert in all areas of counseling. Welfel maintained that for persons making such claims "either some of those skills are underdeveloped, or that person is a fraud" (p. 48).

Intercultural Counseling Competence

Counselor competence and ethical practice include an awareness of diversity issues and a commitment to have or obtain the skills necessary to address diversity issues directly related to the client population a counselor is serving (Corey et al., 2003; Howard, 1990; Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Remley & Herlihy, 2001; Welfel; 2002). The ACA (2005) ethics code states that the counselor "gain knowledge, personal awareness, sensitivity, and skills pertinent to working with

a diverse client population" (Standard C.2.a.). According to the 1995 ACA ethics code, respecting diversity in the counseling process includes factors related to "age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status" (Standard A.2.a.). The standards for diversity counseling were summarized and presented by Arredondo, Toporek, Brown, Jones, Locke, Sanchez, and Stadler in 1996 and endorsed by the Association for Multicultural Counseling and Development and the Association of Counselor Education and Supervision (Remley & Herlihy, 2001).

Diligence

According to Welfel (2002), diligent counselors are willing to put forth extra effort to serve their clients. Counselors who are thorough in their work, willing to refer when necessary, engaged in continued reading and research concerning clinical concerns, and seek consultation with colleagues when clinical questions arise demonstrate diligence (Welfel). Welfel considers counselor self-knowledge as critical to diligence because self-assessment and a consequent understanding of limitations and strengths is foundational to counselors recognizing emerging boundaries of competence concerns in the course of clinical life. A number of authors have referenced the necessity for counselors to be conscientiousness concerning self-awareness and acknowledgment of limits (Corey et al., 2003; Kitchener, 2000; Remley & Herlihy).

Maintaining Competence Necessitates Continuing Education

In regard to competence and continuing education, the *ACA Code of Ethics* (2005) states

> counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They take steps to maintain competence in the skills they use, are open to new procedures, and keep current with the diverse populations and specific populations with whom they work. (Section C.2.f.)

Corey et al. (2007) reported that "most professional organizations support efforts to make continuing education a mandatory condition of relicensing" (p. 311). Remley and Herlihy (2001) indicate that most counselor license renewal procedures involve validation of completed continuing education hours. In 1982 Berger stated that all of the mental health professions recognize the necessity of continuing education in the maintenance of competence.

In a field where knowledge consistently expands and impacts practice application, the need for updating one's knowledge is critical (Corey et al., 2007; Herlihy & Corey, 1996; Kitchener, 2000; Koocher & Keith-Spiegel, 1998). The intent of continuing education is for the professional to stay current in the field (Corey et al.; Kitchener; Remley & Herlihy, 2001; Rinas & Clyne-Jackson, 1988). Maintaining competence is the responsibility of the individual practitioner and can be accomplished through independent reading of current and pertinent materials, involvement in workshops and conventions, and/or participating in consultation (Corey et al., 2003; Herlihy & Corey; Kitchener; Remley & Herlihy; Rinas & Clyne-Jackson).

Research on Boundaries of Competence

According to Koocher and Keith-Spiegel (1998), "there are relatively few published papers exploring conceptualizations of competent psychological practice, and those few are limited in scope" (p. 56). In a review of the literature over the past 2 decades a few studies were found that made reference to competence concerns within the items researched (Gibson & Pope, 1993; Golden & Schmidt, 1998; Haas, Malouf, & Mayerson, 1986; Hayman & Covert, 1986; Neukrug, Milliken, & Walden, 2001; Pope, Tabachnick, Keith-Spiegel, 1987, 1988; Pope & Vetter, 1992). Three studies were found that dealt primarily with counselor competence (Glennon & Karlovac, 1988; O'Malley, Foley, Rounsaville, & Watkins, 1988; Svartberg & Stills, 1992).

Over the past two decades a number of studies have been published that investigated a wide range of ethics concerns. These studies include research on ethics knowledge and awareness (Gibson & Pope, 1993; Zibert, Engels, Kern, & Durodoye, 1998), dilemmas and decision making (Foltz, Kirby, & Paradise, 1989; Haas et al., 1986, 1988; Hayman & Covert, 1986; May & Sowa, 1992; Pope & Vetter, 1992; Smith, McGuire, Abbott, & Blau, 1991) confidentiality (Millstein, 2000), dual role relationships (Borys & Pope, 1989) ethics complaints (Neukrug et al., 2001) practice behavior (Bernard & Jara, 1986; Bernard, Murphy, & Little, 1987; Golden & Schmidt, 1998; Pope et al., 1987, 1988; Robinson & Gross, 1989; Smith et al.; Wilkins, McGuire, Abbott, & Blau, 1990), ethics involved in supervision (Navin, Beamish, & Johanson, 1995), and ethics education (Stadler & Paul, 1986; Robinson & Gross; Schwab & Neukrug, 1994; Tabachnick, Keith-Spiegel, & Pope, 1991). Several of the

practice-based behavior studies, which dealt with the dissonance between what professional mental health practitioners know to do and what they, in fact, report they do in regard to ethics behavior, reported some investigation of competence issues.

Competence Concerns Part of the Larger Study

Haas et al. (1986) conducted a national survey that investigated the actions psychologists would select when confronted with specific ethical dilemmas. Participants were asked to respond to ten vignettes, of which one overtly addressed boundary of competence concerns. The competence concern vignette related to a client's requesting treatment in an area for which the psychologist had general knowledge but no particular expertise. About half of the participants indicated that they would proceed on general knowledge. Haas et al. reported that about half of the participants indicated they would proceed on general knowledge: "about 45% of respondents [reported they] would discuss their qualifications with the client and, apparently, let the client determine the therapist's competence. Clients' ability to make such a determination can be seriously questioned" (p. 320).

Hayman and Convert (1986) surveyed college counselors concerning ethical dilemmas. They reported that counselors found dilemmas related to competence and confidentiality were "more difficult to resolve than other dilemmas" (p. 319). The authors suggested that this result indicated a need for code clarification in these areas of practice.

Pope et al. (1987) surveyed 456 psychologists concerning their ethical beliefs and behaviors. One of the 83 items on the survey addressed boundaries of competency beliefs and behaviors. They reported that close to one fourth of the participants acknowledged having practiced beyond their areas of competence.

Pope and Vetter (1992) had 679 psychologists respond to their national survey, which collected ethical dilemma critical incidents for the purpose of informing APA code revision. The respondents presented 703 incidents divided into 23 categories. Pope and Vetter reported that approximately 3% of the submitted incidents involved boundaries of competence concerns. They offered the following illustrations of these submissions.

> Clients approach me to do therapy on them but have problems I'm not really trained to do . . . . In our small town, political community, colleagues are less well trained and often practice beyond their training and competence level . . . . Some current staff psychologists, trained many years ago [and] have not kept their skills and /or knowledge base current and thus, we have a problem with competence . . . .I often feel exhausted and burned out, but lack supervisory therapy resources for myself. How do I know my own limits? (p. 406)

Gibson and Pope (1993) collected data from 579 counselors who held certification from the NBCC concerning ethics behavior and beliefs. Of the eighty-eight survey items one directly referenced boundary of competence concerns. Three percent of the respondents considered "providing services outside areas of competence" (p. 333) ethical behavior.

Golden and Schmidt (1998) replicated a study done with a wide spectrum of mental health professions practicing in San Antonio, Texas in the late 70's. The authors reported an N of 80 in the late 70's and 170 in the most recent study. The data

were gathered through a questionnaire that focused on the question "by category, how many reliable reports of unethical practice in counseling in this city have you been aware of in the past 2 years?" (p. 166). In the first study "practice by unqualified personnel" (p. 169) was the issue that generated the most concern. The authors pointed out this concern may have been due to the fact that counselors were practicing without licenses because there was no counselor licensure at that time in Texas. In the second study competence was less of a concern, but professionals reported incidents of therapists "treating patients with serious psychiatric conditions or were using specialized techniques for which they had no training or supervised practice" (p. 169).

Neukrug et al. (2001) sent surveys to state licensing boards for credentialed counselors regarding ethical complaints reported to the boards. The surveys listed ten areas of ethical complaints as well as a category for "other." A total of 34 boards responded reporting oversight for a total of 141,403 credentialed counselors. The respondents identified 1,018 filed complaints of which 172 (17%) were for "incompetence in the facilitation of a counseling relationship" (p. 61). This was the second most frequently reported area of filed complaints.

Competency Central to Study

O'Malley et al. (1988) investigated the relationship between therapist competence and patient change in relation to symptoms of depression. The results demonstrated that therapist competence contributed significantly to the reduction in

apathy associated with depression, but not in social adjustment difficulties symptomatic of depressed mood.

Svartberg and Stiles (1992) conducted research which investigated the interplay between patient change, therapist competence, and patient-therapist complementarity in short-term anxiety-provoking psychotherapy. The authors stated that "as yet, the relation of therapist competence to patient outcome is uncertain" (p.304). The results of the study indicated that complementarity of counselor and client was more significant than therapist competence with the particular techniques being used. The authors believed that the small sample size, the competence measures used, and the screening system used in therapist selection for the study may have weakened the results. Svartberg and Stiles recommended the study be viewed as a pilot study that would inspire further studies on competence and outcome.

Glennon and Karlovac (1988) investigated the influence of fee levels on therapists' self-perceived competence level. The study found that therapist trainees using nonpsychodynamic treatment modalities viewed themselves as more competent when charging a high fee and less competent when charging a lower fee. In contrast, competence self-perception for those participants using psychodynamic treatment modalities did not appear affected by fee level.

Multicultural Competencies

Although Coleman (1998) acknowledged there is a common understanding that "general and multicultural counseling competencies are distinct constructs" (p. 147),

he pointed out there is not a clear understanding of the relationship between these constructs. The discussion of distinctions between general and multicultural competence is beyond the scope of this study and only a sampling of the research specific to multicultural counseling competencies will be offered here. According to Pope-Davis et al. (2002), "multicultural competence is a burgeoning area of research" (p. 355). This growing interest in multicultural competence has generated a number of studies investigating a range of issues on this specific area of competence including ethics concerns (Lee & Kurilla, 1997) competence from the client's perspective (Pope-Davis et al., 2002; Coleman, 1998; Constantine, Kindaichi, Arorash, Donnelly, & Kyung-Sil,2002) counselor self-assessment (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000), and counselor attitudes (Constantine, Juby, & Liang, 2001).

Boundaries of Competence and Ethical Decision Making

Rinas and Clyne-Jackson (1988) and Welfel (2002) clearly set out the two options available to counselors facing boundaries of competence concerns as continued treatment after "acquiring new skills or entering new areas of specialty" and referral. A search of the literature for ethical decision-making models specific to resolving boundaries of competence concerns yielded no models specifically offering an ethical decision-making model limited to boundaries of competence concerns. However, within the body of literature addressing competence issues, there are three basic concepts regarding ethical decisions when boundaries of competence issues emerge in the therapeutic process. The first involves identification and clarifying

competence limits and specific clinical situations. The second is the possibility of continuing treatment. The third concept relates to the option of termination and referral.

The review of ethical decision making and boundaries of competence concerns will be presented in three sections: (a) identifying and clarifying abilities within specific clinical settings; (b) continued treatment as a resolution of the concern; (c) termination and referral as a resolution of the concern. There is some overlap between the common components in ethical decision-making models presented earlier in this chapter and the discussion of ethical decision making and boundary of competence concerns in this section. The identifying and clarifying section has a number of parallels to the working with the client component (Table 8). The resolution sections, which include continue treatment and termination/referral options, parallel the action steps common components (Table 10) found earlier in this chapter. However, the continue treatment resolution section also includes consulting literature and colleagues components discussed in the information gathering common components summarized in Table 9. Components overlapping those presented within the ethical decision-making model common components section are reviewed in this section with a focus on their applicability to ethical decision making specific to dealing with boundaries of competence concerns

Identifying and Clarifying

Identifying and clarifying includes two areas for consideration. First is counselor

self-awareness of abilities and limits. The second is counselor consideration of the viability of possible resolution options. This includes requirements involved in entering a particular new practice domain and available resources. A more generic discussion of identification and clarification as a component of ethical decision making is offered throughout the presentation of ethical decision-making models and summarized in Table 9.

Corey et al. (2007) gave the following advice to counselors in training about identifying and clarifying their competence in encountering clients who they are concerned may challenge their competence levels.

> As a beginning counselor, if you were to refer all the clients with who you encountered difficulties, you would probably have few clients. You must assess how far you can safely go with clients and recognize when to refer clients to other specialists or when to seek consultations with other professionals. You are not alone when you have doubts about your general level of competence. In fact, it is not at all unusual for even highly experienced therapists to wonder seriously at times whether they have the personal and professional abilities needed to work with some of their clients. It is more troubling to think of therapists who rarely question their competence. Thus, difficulty working with some clients does not by itself imply incompetence, nor does lack of difficulty imply competence. (p. 315)

Corey et al. (2007) followed this advice with some suggestions for upgrading skills such as intentionally working with more experienced counselors, taking courses beyond the required basics, participating in conferences and conventions, and pursuing specialty training. They also recommended participating in workshops providing supervision opportunities in addition to didactic learning. Additionally, Corey et al. indicated that when counselors cannot acquire knowledge quickly enough or stay ahead of the process well enough to safely treat the client, they need to refer.

Haas and Malouf (1995) suggested some guidelines for counselors to use in determining their competence level in difficult situations. These questions fall into five basic categories and encompass all of the areas of consideration within the discussion of identifying and clarifying.

1. Relevant standards: Haas and Malouf encouraged counselors to identify whether the work needed falls under a specialty for which the professions have developed a set of standards or one in which there are no set specialty standards. When there are no set specialty standards, Haas and Malouf encouraged counselors to consider thinking through the distinction between mandatory and aspirational ethics.
2. Research, theory, and consultation: Within this category counselors are encouraged to assess whether or not research and/or theory support their planned interventions. Counselors are instructed to consult both colleagues with relevant experience and pertinent literature. In cases that are not "rare or previously unheard of" (p. 28) Haas and Malouf indicated the standard of care assumes the professional has "access to the sources of information that would allow them to stay current with nationally emerging findings" (p. 29). The authors additionally point out that within this category the counselor is expected to be able to discern good research design and study and thus be capable of evaluating the merit of a given article or report found in the literature. The authors argue that this is especially critical when the

literature presents articles with opposing or varied views on techniques or issues encountered within clinical settings.

3. Context: The clinical context (e.g., geographical location, agency) of the situation will determine what, if any, reasonable alternatives are available. Counselors are encouraged to consider the "client's perception of alternatives" (p. 30) as part of the context.
4. Counselor's Emotional Capacity: Haas and Malouf suggested an emotional inventory might include consideration of countertransference, personal stresses, and lack of engagement with the client. Because counselor resistance and repression are as much a part of the therapist's makeup as they are of the clients' system, the authors suggested therapists seek feedback from peers.
5. Peer Review: Haas and Malouf argued that one safeguard against practicing beyond one's competence is to stay actively engaged in the professional community. The authors encouraged counselors to consider whether or not they could justify their decision to treat or refer to their group of peers. They suggested that "the 'clean, well-lit room' standard can prove very useful in making decisions about one's competence to handle a particular situation" (p. 31).

Counselor Awareness of Competence Limits

Several authors posed questions around the quandary counselors face in knowing

how to measure their competence level in general and how to discern competence in the presence of a specific clinical situation in which questions of boundaries of competence emerge (Corey et al., 2003; Remley & Herlihy, 2001; Welfel; 2002). Some (Haas & Malouf, 1995; Millard, 1997) suggested that therapists will be aided in measuring competence by understanding competence as fluid process, dependent on context, and influenced by variant environmental factors. Haas and Malouf argued that the "major issue here is defining what are general clinical principles that transcend particular contexts, and what are specific 'micro-competencies' or circumstances" (p. 26). Rinas and Clyne-Jackson (1988) listed four areas of consideration counselors need to attend to in discerning limitations. They argued that clinicians should say "no" to a case if they have (a) an understood deficiency in skill needed to address the particular client's difficulty, (b) unresolved personal issues related to the client's area(s) of concern, (c) a known history of failure with certain client populations, (d) a lack of interest in areas or kinds of problems requiring treatment, and (d) physical limits or impairment including illness and burnout.

Haas and Malouf (1995) pointed out that although competence is hard to define and questions around competence in particular clinical situations do not always have simple answers found in standards and/or the literature, it is the individual practitioner who "will be held responsible for the delivery of competent services" (Haas & Malouf, p. 26). Koocher and Keith-Spiegel (1998) took the position that the responsibility for this discernment process begins with the professional knowing her or his limits well enough "not to take on clients that one is not adequately prepared to

treat or knowing enough to help clients in need of different services to find them early in the relationship rather than waiting until problems develop" (p. 73). In contrast, Corey et al. (2003) argued that there are a number of questions related to understanding competence limits, including how "practitioners determine whether they should accept a client" (p. 294), that are left unanswered in the standards and in the literature. Although Remley and Herlihy (2005) recommend counselors screen potential clients and not engage clinically with those whose difficulties exceed their competence, they also recognize that it is impossible to screen for all of the potential concerns emerging during the course of therapy.

Viability of Possible Resolution Options

After counselors have assessed their own competence limitations in a given clinical situation, they will need to assess the viability of the possible resolution choices. The choices presented in the literature are to continue treatment or terminate and refer (Corey et al., 2003). In deciding between these choices, there are several factors mentioned in the literature that may play into the process of decision making. As counselors are considering whether to continue treatment or terminate and refer, they may need to consider the implications of entering a new practice domain (Corey et. al, Hass & Malouf, 1995, Welfel, 2002), availability of referral options in their given geographical setting, and/or the accessibility of professionals trained and experienced in dealing with the issues of concern (Welfel).

New practice domains. Corey et al. (2003) argued counselors need to take on at least some cases that will stretch them and also that counselors have the right to enter new practice domains but must do so in a responsible manner. According to the *ACA Code of Ethics* (2005), counselors are responsible to seek education, training, and supervised experience when entering new specialty areas of practice. Although the AMHCA (2000), NBCC (2005), and NCDA (2003) codes reference competent service as including only those clinical areas and intervention techniques for which the counselor has training and/or experience, none of the three articulates guidelines of developing new practice domains. Table 14 lists the statements that speak directly to new practice domain standards found in two of the five ethics codes most relevant to the counselors who participated in this study. Table 15 cites statements found in the APA, NASW, and AAMFT codes of ethics related to new practice domains.

It is apparent from the statements listed in Tables 14 and 15 that there is a consensus within mental health professions concerning new practice domains. The standard clearly states that counselors who decide to continue treatment and thus enter a new practice domain must take steps to the engage in relevant education, training, and supervised experience. The APA (2002) and NASW (1999) standards add the concepts of reviewing relevant research and engaging in study, and thus underscore two areas of training and preparation needed to for competent practice in new specialty areas. The exact duplication of wording within the ACA *Code of Ethics* (2005) and the *Code of Professional Ethics for Rehabilitation Counselors* (2001) gives

further credence to consensus within the counseling profession that counselors must engage in training and supervised experience to work in a new practice domain.

Hass and Malouf (1995) raised the question of how much training is enough to qualify the counselor to work in a new practice domain and placed the responsibility for that assessment on the shoulders of the individual practitioner. They stated,

> How much knowledge is enough? Is one class enough? Is a 20-day workshop enough? Is reading a couple of books and talking to peers enough? . . . These questions are not easily resolved. No credentialing body can possibly anticipate all possible situations a practitioner is likely to encounter and establish standards accordingly. Yet at the same time, the practitioner will be held responsible for delivering competent services even in the absence of such standards. (p. 26)

Table 14

Counselor Code New Practice Domain(s) Statements

Code	New Practice Domain(s) Statement
ACA (2005)	Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm. (Section C.2.b.)
CRCC (2002)	Rehabilitation counselors will practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, rehabilitation counselors will take steps to ensure the competence of their work and to protect clients from possible harm. (Section D.1.c.)

Table 15

Psychologists, Social Workers, and Marriage and Family Therapists Code New Practice Domain Statements

Code	New Practice Domain(s) Statements
APA (2002)	When psychologists are asked to provide services to individuals from whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study. (Section 2.01(d)) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect client/patients, students, supervisees, research participants, organizational clients, and others from harm. (Section 2.01(e))
NASW (1999)	Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques. (Section 1.04 (b)) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm. (Section 1.04 (c))
AAMT (2001)	While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience. (Principle 3.7)

Kitchener (2000) recognized that on occasion counselors will encounter areas of practice for which there is no standard established and that in such situations counselors "should take reasonable steps to ensure their competence and protect consumers and others with whom they work from harm" (p. 154). Given the standards put forward in the codes and the advice found in the literature, before making a choice about continued treatment or referral, individual practitioners need to identify and assess the availability of training and the supervised experience options. According to Pope and Vasquez (1991), they will also need to evaluate whether they have the "time, energy and the commitment necessary" for becoming competent in the area of concern (Pope & Vasquez).

Geographical setting. A number of authors (Helbok, 2003; Kennedy, 2004; Koocher & Keith-Spiegel, 1998; Pope & Vasquez, 1991; Rinas & Clyne-Jackson, 1988; Welfel, 2006) indicated that geographical setting may influence the choice to continue treatment or refer after the awareness of a boundaries of competence concern arises. These authors pointed out that there is often a shortage of mental health service providers located within an accessible distance for clients in rural areas and thus referral is not a reasonable option. They also noted that counselors practicing in small towns or rural areas often need to be generalists and cannot spend the time developing specialties.

There is a lack of available mental health providers located within accessible distances of rural communities, and thus, there are limited or nonexistent options for referral (Helbok, 2003; Kennedy, 2004; Pope & Vasquez, 1991; Welfel, 2006). Welfel

compared the option of referral between counselors located in urban/suburban and rural settings. She noted that counselors practicing in small towns or rural settings have few referral resources located within reasonable travel distances for their clients. Kennedy and Welfel pointed out that rural clients often will not seek counseling services requiring distance travel. Kennedy stated that the need to travel some distance to secure mental health services is "a major factor in why people living in rural communities typically do not seek assistance" (p. 1). According to Helbok, Kennedy, and Welfel, this lack of available mental health practitioners leads to a need for rural counselors to be generalists. Kennedy highlighted the fact that because a needed referral may be "100 miles away, rural counselors need to be well-versed in a variety of areas" (p. 17).

Some guidelines for rural counselors facing the dilemma of practicing beyond their competence and lacking reasonable referral options have been offered (Koocher & Keith-Spiegel, 1998; Welfel, 2002). Koocher and Keith-Spiegel offered a three-part strategy that included (a) counselors being sure they have researched all resources within the community, (b) using "ongoing, supportive consultation by telephone with a colleague who does have the proper competences" (p. 68), and (c) understanding that when client needs and counselor competencies are too disparate, a situation in which the risk of doing harm is greater than the potential for good will exist. In these cases counselors should not proceed with treatment. Welfel argued that counselors need to balance the principle of nonmaleficence or doing no harm and the principle of beneficence or doing good. She explained,

> Clients who are at risk for harm from an incompetent counseling intervention are better served by a referral, no matter how inconvenient. Second, counselors should evaluate the opportunity to do good and should compare the risk of harm to the opportunity to help. If the risk of harm is high and the chance to help is less high, then a counselor should refrain from intervention. If the risk of harm is low and the opportunity to do good is significantly greater, then the intervention can be considered. In this case rural counselors should use inventive strategies to enhance their knowledge and gain access to appropriate supervision. (p. 55)

The statement "the undisputed facts are that not all people are helped by therapy and that some are actually harmed by it" (Koocher and Keith-Spiegel, p. 68) brings a sobering reality underscoring Welfel's guidelines.

It has been pointed out that rural counselors sometimes see patterns of clinical presentation within their particular communities (Pope & Vasquez, 1991: Rinas & Clyne-Jackson, 1988; Welfel; 2002) and/or they are faced with a constant influx of new clinical issues (Pope & Vasquez). Pope and Vasquez, Rinas and Clyne-Jackson, and Welfel also argued that when rural counselors see a pattern of clinical presentation, they have a responsibility to seek training, consultation and/or supervision related to the emergent community mental health need(s). Pope and Vasquez suggested that because counselors who work in less densely populated areas "frequently encounter unfamiliar problems" (p.47), they need to be continually seeking out education for new practice areas and may even need to engage in consultation with experts who live some distance from their place of practice in order to ensure delivery of competent care.

Resolution of Concern: Continue Treatment

The choice to continue treatment is one of two viable options for counselors

facing boundaries of competence concerns. Counselors may select continued treatment in a new practice domain as resolution for their boundaries of competence concern but they are ethically bound to follow the ethical standards set out in the codes for entering new specialty areas (Corey et. al, 2003). It should be noted that Remley and Herlihy (2005) listed creating a team approach as a continued treatment option. They suggested referring clients for work on the areas of concern to an expert while continuing to work with the client on other issues within the counselor's' boundaries of competences.

Counselors electing to continue treatment are encouraged to give consideration to the possible necessity for further training related to the new practice domain(s) (Pope & Vasquez, 1991). The literature on new practice domains clearly outlines further training and supervision with professionals who have knowledge and experience in the area of concern as an essential part of a continued treatment plan (Pope & Vasquez, 1991; Rinas & Clyne-Jackson, 1988; Welfel; 2002). Herlihy and Corey (1996) highlighted the importance of counselor engagement in training and supervision while entering new practice domains, stating that counselors "take steps to ensure the competence of their work and to protect others from possible harm" (p. 219).

Consulting colleagues, which includes supervision and networking as well as formal consultation, is one of the items set out in the elements found in ethical decision-making models reviewed for this study. Table 9 contains a summary of the consultation component in the ethical decision-making models. Hill et al. (1995)

incorporated consultation with several steps of their model. The primary models of Corey et al. (2007), Forester-Miller and Davis (1996), Remley and Herlihy (2005), and Welfel (2002) included consultation either as a full step within the process or emphasized the need for consultation as a part of several steps. The secondary models of Cottone (2001, 2004), Tymchuk (1981), Haas and Malouf (1995), Stadler (1986), and Garcia et al. (2003) urged counselors to seek consultation during the ethical decision-making process. In the social constructivism model of Cottone, consultation is the central pillar of the decision-making process. Consultation is obviously a key component in ethical decision making, but because none of the models dealt with the steps involved in selecting continued treatment, specific mention of post-decision supervision would not be expected. Likewise, the necessity for continuing education as a fundamental element of competent practice was discussed earlier in this chapter but was not linked to a resolution for continued treatment.

Resolution of Concern: Termination and Referral

Once the decision to terminate the process of counseling because of boundaries of competence concerns has been made, the counselor must attend to appropriate ethical procedures (Corey et. al. 2003; Remley & Herlihy, 2005). A full discussion of the literature discussing termination and referral is beyond the scope of this review. However, a brief discussion is warranted here, as neither termination nor referral is discussed elsewhere in this review of literature, and both are key components for counselors when resolving boundaries of competence issues. Discussion begins with a

presentation of statements in ethics codes relevant to termination and referral. A brief review of selected literature on termination and referral concludes this section.

Ethics Codes Statements Relevant to Termination and Referral

According to the ethics codes relevant to mental health practitioners, ethical termination of a client who still needs counseling services must be accompanied by a referral process or counselors will be abandoning the client and thus be in violation of the codes. Table 16 contains the statements related to referral and abandonment from the codes directly applicable to the participants in this study. Table 17 contains statements form the APA, NASW, and AAMF codes relevant to termination and referral.

Brief Review of Selected Literature on Termination and Referral

Importance of Termination and Referral in Counseling. Leigh (1998), Barnett and Sanzone (1997), and Boyer and Hoffman (1993) argued termination is an important part of the counseling process. They indicated that successful treatment outcomes are linked to effective termination and suggested counselors initiate discussion about termination in the first appointment. According to Leigh, termination is a fascinating and multifaceted process. She stated,

> There are many important and fascinating issues raised for the counsellor when contemplating aspects of referral and termination of clients in counselling. There are the decisions that have to be made about the appropriateness of referral of a client to an alternative avenue of therapy or help, how to handle referrals from other practitioners, and how to deal with the process of termination of

Table 16

Counselor Code Regarding Termination and/or Referral

Code	Termination and Referral Statements
ACA (2005)	Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacation, illness, and following termination. (Section A.11.a.)
	If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationship. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors should discontinue the relationship. (Section A.11.b.)
	Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client, or another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary. (Section A.11.c.)
	When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners. (Section A.11.d.)
AMHCA (2000)	Mental health counselors do not abandon or neglect their clients in counseling. Assistance is given in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacation and following termination. (Principle 1.P)
	Mental health counselors terminate a counseling relationship, securing a client's agreement when possible, when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the needs and interests of the client, when clients do not pay fees charged, or when agency or institution limits do not allow provision of further counseling services. (Principle 1.R)

(Continued on following page)

Table 16 (continued)

Counselor Code Regarding Termination and/or Referral

Code	Termination and Referral Statements
NBCC (2005)	When certified counselors determine an inability to be of professional assistance to a potential or existing client, they must, respectively, not initiate the counseling relationship or immediately terminate the relationship. In either event, the certified counselor must suggest appropriate alternatives. Certified counselors must be knowledgeable about referral resources so that a satisfactory referral can be initiated. In the event that the client declines a suggested referral, the certified counselor is not obligated to continue the relationship. (Section B.10.)
NCDA (2003)	When NCDA members determine an inability to be of professional assistance to a potential or existing client, they must, respectively, not initiate the counseling relationship or immediately terminate the relationship. In either event, the career counselor must suggest appropriate alternatives. Career counselors must be knowledgeable about referral resources so that a satisfactory referral can be initiated. In the events that the client declines a suggested referral, the career counselor is not obligated to continue the relationship. (Section B.11.)
CRCC (2002)	Rehabilitation counselors will not abandon or neglect client in counseling. Rehabilitation counselors will assist in making appropriate arrangements for continuation of treatment, when necessary, during interruptions such as vacations, and following termination. (Section A.9.a.) If rehabilitation counselors determine an inability to be of professional assistance to clients, they will avoid entering or immediately terminate a counseling relationship. (Section A.9.b.) Rehabilitation counselors will terminate a counseling relationship, securing client agreement when possible, when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the client's needs or interests. (Section A.9.c.) Rehabilitation counselors will be knowledgeable about referral resources and suggest appropriate alternatives. If clients decline the suggested referral, rehabilitation counselors have the right to discontinue the relationship. (Section A.9.d.)

Table 17

Psychologists, Social Workers, and Marriage and Family Therapists Code Regarding Termination and/or Referral

Code	Termination and Referral Statements
APA (2002)	Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service. (Section 10.10 (a)) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship. (Section 10.10 (b)) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate. (Section 10.10 (c))
NASW (1999)	Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the client's needs or interests. (Section 1.16 (a)) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary. (Section 1.16 (b)) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences. (Section 1.16 (d))
AAMT (2001)	Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment. (Principle 1.11)

> counselling. There may be powerful feelings for both client and counselor which we need to be able to handle in a caring and professional way. (Leigh, 1998, p. 1)

Following the introduction to her text on termination and referral issues, Leigh (1998) discussed the crucial nature of the skill set required for a positive clinical termination and referral process. Corey et. al (2007) talked about the process of making a positive referral as being a learned skill. They instructed counselors in training in this area stating, "You will need to learn how to make this referral in such a manner that your client will be open to accepting your suggestion rather than being harmed by it" (p. 318). Leigh (1998) argued that because no one person can be all things to all people, counselors need to develop referral skills that can be applied during any phase of the therapeutic process.

Barnett and Sanzone (1997) contended that the manner in which termination is planned and executed can determine client trust in future treatment. Clyne-Jackson (1988) suggested that a positive termination and referral process is "mutual or collaborative in nature" (p. 190). However, even in the best of terminations, Quintana and Holahan (1992) suggested counselors need to develop the skills and sensitivity necessary to manage potentially intense emotional reactions on the part of clients. According to Siebold (1991), this emotional response is to be expected, as it is a direct result of the therapist breaking the bond of therapy they have worked so hard to create.

In spite of the acknowledged importance of termination and referral in the counseling process and the significance of developing skills related to both, comparatively little attention has been given to theory, research, and training in these

areas (Boyer & Hoffman, 1993; Halgin & Caron, 1991; Leigh, 1998; Quintana & Holahan, 1992; Ramsey, 1962). According to Quintana and Holahan (1992), there has been little research done related to termination. Ramsey stated,

> Referral is an old, recognized, and frequently used aspect of counseling, but a survey of the literature shows that is it a much neglected topic. It is only meagerly treated in training textbooks and professional journals and almost totally neglected as an area of research. (p. 443)

Boyer and Hoffman believed both counselor and client are impacted by termination, and pointed out that although little attention has been given to how termination impacts clients, even less attention has been given to the "emotional reactions of the counselor" (p. 271). Halgin and Caron pointed out that mental health professionals frequently deal with the question of whether or not to accept or refer a new client based on competence issues. They called this the issue of "client suitability" (p. 88) and pointed out that "surprisingly little has been written on the topic" (p. 87). Leigh stated that "although referral is an important issue for counsellors, there is little reference to the topic in the therapeutic literature" (p. 7).

Ramsey's 1962 comments about referral being "meagerly treated in training textbooks" to some degree also applies to today's textbooks for training counselor as well. Three of the texts commonly used in counselor education programs to teach ethics (Corey et. al, 2007; Remley & Herlihy, 2005; Welfel, 2006) dedicate very little space to the subjects of referral and/or termination. Training in basic intervention skills would be the other natural place to expect some training in the areas of termination and/or referral, but in two of the texts (Egan, 1998; Ivy & Ivy, 2003) widely used in counselor education programs to teach this subject matter, no space is

given to either of these concerns. In a text developed by Hill and O'Brien (1999) for training mental health professions in basic skills, a small amount of space is dedicated to the issues of determining when and how to terminate and/or refer.

Termination Includes Referral in Boundaries of Competence Situations. The literature on termination as a resolution to a boundaries of competence concern necessitates offering clients referral options (Barnett & Sanzone, 1997; Corey, et. al, 2007; Halgin & Caron, 1991; Remley & Herlihy, 2005; Van Hoose & Kottler, 1988; Welfel, 2006). According to Remley and Herlihy, requiring referral to be coupled with termination for clients who need further work is in keeping with the codes of ethics. According to Rinas and Cline-Jackson (1988), offering a referral option is not only a matter of ethical accountability, it is a legal responsibility. There is only one exception to this overriding rule found in the literature and the ethics codes. The exception applies to mental health professionals in rural locations where there is no viable referral option and the counselor has determined continuing treatment would be more harmful to the client than to terminate without referral (Welfel).

The reality is that clients may reject the suggestions for referral and choose to end their involvement in treatment altogether. If a client makes this choice, and the counselor has documented his or her recommendations for referral along with a rationale for termination, the counselor is no longer held ethically or legally responsible for the client's well being (Barnett & Sanzone, 1997; Remley & Herlihy, 2005). Barnett and Sanzone have pointed out that although counselors are required to

couple the termination decision with referral options, clients cannot be forced to accept the referral.

Factors contributing to a positive referral process. A review of the literature on referral gives insight into the components necessary for a positive referral process. Counselors must work to accomplish an ordered and positive transition when possible (Rinas & Cline-Jackson, 1988). They also need to be prepared to make an appropriate referral when the need arises. According to Van Hoose and Kottler (1988) and Leigh (1998), competent counselors maintain an awareness of and/or a list of potential referral resources in their community. Barnett and Sanzone (1997) argued appropriate referral includes consideration of the "referral resource's training and experience, cost, location, and accessibility" (p. 11). Several other authors also emphasized the need for counselors to ensure that the receiving counselor is known to be competent and/or have an expertise in the area(s) of concern (Koocher and Keith-Spiegel, 1998; Van Hoose & Kottler; Welfel, 2002). Remley and Herlihy (2005) suggested counselors give clients several referral sources. Counselors are encouraged (Barnett & Sanzone; Remley & Herlihy) to put their recommendations for referral in writing for clients.

Counselors need to work with their clients in the process of making a transfer (Barnett & Sanzone, 1997; Corey et. al; Halgin & Caron, 1991; Koocher and Keith-Spiegel, 1998; Quintana and Holahan, 1992; Remley & Herlihy, 2005; Siebold; 1991). Several authors (Halgin & Caron; Remley & Herlihy) suggested having honest discussions with clients about the concerns that generated the need for referral. Koocher and Keith-Spiegel argued that it is normative and even ideal for the

competent therapist to discuss plans with clients. Remley and Herlihy recommended offering clients several termination sessions.

Discussion on the process of termination and referral concludes with the following quote from Rinas and Clyne-Jackson (1998), summarizing many of the elements found in this brief literature review on termination and referral.

> Referral to a professional competent in areas relevant for that client is another route to follow and is often the simplest and most efficient solution. In pursuing this route, the referring agent is responsible for arranging a smooth and positive transfer of the client. As a part of this responsibility, the referring professional must be confident that the other individual does indeed have the necessary expertise and is receptive to taking on the client in question. The decision to refer the client elsewhere must be discussed within the context of the therapy session so that the client has an opportunity to deal with his or her feelings about this change and to decide whether to allow the referral to take place. (p. 39)

RESEARCH TOOL

The research tool selected for this study was a qualitative face-to-face interview built around a conceptual mapping task. Martin introduced the conceptual mapping task into counseling research in the mid 1980s (Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989) in a study designed to explore the differences in how novice and experienced counselors conceptualize client processes and concerns. A search of the literature and personal communication with Martin (July, 2002) revealed no other counseling literature that incorporated the use of conceptual mapping in counseling research subsequent to the Martin study.

Conceptual mapping has been used to generate ideas, teach concepts, and illustrate principles in education since 1984 (Deshler, 1990). The creation of

conceptual mapping is generally credited to Novak of Cornell University and has been applied in numerous settings for education and training purposes (Trochim, 1993; Deshler; Wiig & Wiig, 1999). The terms *concept mapping* and *conceptual mapping* seem to be used interchangeably in various training areas.

A number of descriptions and definitions have been offered for conceptual mapping. Wiig and Wiig (1999) described conceptual maps as visual tools that "provide explicit structures for organizing the elicited associations to form templates for communicating and understanding a situation and acting effectively" (p. 8). Deshler (1990) defined concept maps as a "holistic, spatial, hierarchically constructed representation of the relationships among essential concepts" (p. 337) and further explained that concept maps can be used to link complex ideas. He also believed that conceptual mapping exercises assist in "transforming linear material into more holistic visual [images]" (p. 338) and provide "transformative" (p. 338) educational experiences.

Martin (1987) introduced the conceptual mapping task as a research tool for counseling research as a two-phase process. Cummings et al. (1990) described the two phases of the CMT as "(a) a free-association task used to generate a number of concepts, and (b) a conceptual mapping on paper of the concepts generated" (p. 121). The research study required the researcher to record participant free-association responses on small notepaper during the free association phase. During phase two participants were given a large sheet of paper and instructed to arrange the notes on

the larger paper in a manner indicating how the notes formed concepts and how the concepts were related (Martin et. al, 1989).

CHAPTER 3

METHODS

This chapter describes the research design, participants, instrument, and procedures involved in gathering data, including participant selection and interview format. The discussion of methods concludes with a description of the procedures used in data analysis and a restatement of the four research questions.

RESEARCH DESIGN

The purpose of this study was to explore ethical decision-making processes in relation to boundaries of competence concerns as reported by professional counselors. In particular this study addressed the counselor's process when he or she encounters ethical dilemmas precipitated by boundaries of competence concerns. The qualitative research design was based in grounded theory methodology (Glaser & Strauss, 1967), and used a single four-phase interview for data collection. The interview format was based on the conceptual mapping task (CMT) interview model first reported by Martin, Slemon, Hiebert, Hallberg, and Cummings (1989) and later described in detail by Cummings, Hallberg, Martin, Slemon, and Hiebert (1990). A brief discussion of qualitative grounded theory research and a description of the CMT interview model are presented in this section. A more extensive discussion of the interview instrument

is covered in the instrument section with the details for implementation of the interview instrument presented in the procedures section.

Grounded Theory

Grounded theory methodology was first presented by Glaser and Strauss (1967). Glaser and Strauss believed that when theory is developed from data, it enables explanation and prediction of behavior, and is useful for practical application in the social sciences. According to Strauss and Corbin (1994), grounded theory "is a general methodology for developing theory that is grounded in data systematically gathered and analyzed" (p. 273).

A central feature of the grounded theory approach is often referred to as the "constant comparative method" (Strauss & Corbin, 1994, p. 273). It is the constant comparative analysis of the data that informs continued direction of data collection. In grounded theory, the theory evolves as the researcher is involved in the constant comparative analysis process (Strauss & Corbin).

Conceptual Mapping Task

The CMT interview reported by Martin and his colleagues (Martin, Martin, Meyer & Slemon, 1986; Martin, Slemon, Hiebert & Cummings, 1989; Cummings, Hallberg, Slemon & Hiebert, 1990) was developed to examine how novice and experienced counselors conceptualize a client's process and concerns. The CMT interview consists of two parts: "(a) a free-association task used to generate a number

of concepts, and (b) a conceptual mapping on paper of the concepts generated" (Cummings, et al., 1990, p. 121). The first part of the Cummings et al. interview, or the free-association phase, involved me requesting the counselor to free associate in response to a stimulus question for one minute. While the counselor verbalized his or her responses to the stimulus question, I used small rectangular gummed stickers to record the counselor's responses. The second part of the interview was the creation of the conceptual map. At this point the counselor was instructed to arrange the gummed stickers into a visual representation of the relationships between the different concepts. The counselor was then asked to draw lines between closely related concepts. Finally, the counselor was asked to draw circles around clusters of concepts and then label the circled clusters. Martin et al. (1989) believe that the conceptual maps in their study provide rich data for understanding counselor conceptualizations and suggest that this project is a possible starting point for future research.

The research tool used in this study followed the Martin CMT format. The interview tool used was a four-phase interview that incorporated the CMT in the second and third phases. Participants in phase two of this study were asked to tell the story of a case where they had encountered a boundaries of competence difficulty. As each story was told I recorded participant statements on small rectangular Post-it® notes. Phase three followed the same steps as the Martin CMT format. Participants were asked to arrange the Post-it® notes into a visual representation of the relationships between the different concepts, draw lines between closely related concepts, draw circles around clusters of concepts, and then label the circled clusters.

Participants

Participants for this study were drawn from the two levels of counselor licensure in the state of Illinois. These two population samples were clearly defined in the state of Illinois by the Illinois Professional Counselors and Clinical Professional Counselor Licensing Act (2003). The two levels of licensure in the State of Illinois are the Licensed Professional Counselor (LPC) and the Licensed Clinical Professional Counselor (LCPC), and formed the two comparative groups in this study. The list of licensed counselors used in this study was published in March 2002, and as of this date there were 1,394 individuals holding the LPC credential and 3,643 individuals holding the LCPC credential in the state of Illinois (S. Lanzotti, personal communication, March 4, 2002).

LPCs and LCPCs were selected from the Illinois State list of Licensed Clinical Professional Counselors (LCPC). In the state of Illinois the LPC license is granted to the novice counselor upon graduation with a master's degree from a counseling or related program with documentation of required courses and successful completion of the National Counselors Examination (Illinois Professional Counselor and Clinical Professional Counselor Licensing Act, 2003). According to the Illinois Professional Counselor and Clinical Professional Counselor Licensing Act (2003), the LCPC is granted to those counselors who have "completed two years of full-time satisfactory supervised employment or experience working as a clinical professional counselor under the direction of a qualified supervisor subsequent to the degree" (Section

45.b.3.A), and have passed the National Clinical Mental Health Counselor Examination.

Four criteria for selection of participants were established. The first criterion required each participant be either an active Licensed Professional Counselor or Licensed Clinical Professional Counselor in the state of Illinois with no history of professional disciplinary action. Because it is reasonable to assume that disciplinary action would involve some concern involving an ethics violation, any counselor designated on the LPC or LCPC list with the professional discipline designator was screened out of the study. The second criterion required participants be able to cite a clinical experience when they had encountered a boundaries of competence concern. The study was limited to those counselors who indicated they could demonstrate this clinical concern in the context of an individual clinical case. The third criterion required being able to illustrate a case of boundaries of competence concern from clinical experience in a setting that allowed them to fully engage in the ethical decision-making process. Potential participants had to have worked in a clinical setting they believed gave them final decision-making power in boundaries of competence concern situations. Finally, participants demonstrating a reflective communication style during the phone interview were invited to participate in the study.

Participants were screened in the phone interview for the last four criteria listed above. During the phone interview, each potential participant was asked two questions, screened for criteria two and three.

The first question screened for participant ability to cite a clinical experience in a boundaries of competence concern situation had been encountered. This question requires a simple "yes" or "no" response and was stated as follows:

> It is impossible for training programs to prepare counselors for the wide scope of client situations that can be presented in counseling sessions. Sometimes even experienced counselors report that they find themselves faced with complex situations in which they question if they are over their heads. In your clinical work, have you ever encountered a client that caused you to wonder whether or not your training, skills and/or experience were adequate or best for a particular client?

If the potential participant responded with "yes," he or she continued to be considered for the study. If the response to this inquiry was "no," the individual was no longer considered for the study.

For the potential participant who responded with a "yes" to the initial question in relation to experience with boundaries of competence concerns, the interviewer then asked the following question:

> In the clinical work setting or settings where you have encountered concerns about your training, skill or experience level, what freedoms and/or limitations have you experienced when making treatment decisions concerning continued treatment? For instance, have you been allowed to struggle with a particular client issue until *you* decided to change treatment strategies or did your supervisor or employer require that you terminate the clinical relationship because of agency or institutional policy?

I noted the response to this question and assessed the individual's capacity for successful completion of the four-phase interview and thus inclusion in the study. A detailed outline of each phase of the interview process is located in Appendix B.

The third criterion required participants to be verbally reflective individuals. Merriam (1988) reported that the good respondent or informant for a qualitative

interview is one with the ability to reflect on the subject matter in an articulate manner. In their presentation of grounded theory research, Glaser and Strauss (1967) indicated that it is important for the researcher to choose participants who will be able to contribute the fullest possible data for creating categories and their properties. Glaser and Strauss also suggested that the selection include consideration of participant's ability to help in generating relationships between categories. At the end of the phone interview, the potential participant was asked to briefly reflect on his or her experience and style as a professional counselor. This question was specifically designed to encourage interviewees to demonstrate their ability to reflect and articulate about their own professional life and to assist the researcher in evaluating the "story telling" or reflective nature of the potential participant. I noted the response to this question and made a determination about the participant's potential ability to make a contribution to the research study.

Interview Instrument

The instrument for this study was a single four-phase, audio taped, qualitative interview. The initial phase of the interview was designed for rapport building with the interviewee and demographic data gathering. The second and third phases of the interview were the core of the interview design and were an adaptation of the two-part CMT reported by Martin, Martin, Meyer and Slemon (1986), Martin, et al. (1989), and Cummings, et al. (1990). The first three phases were designed to follow the pattern of a structured qualitative interview, but the fourth phase followed the pattern of the

semi-structured qualitative interview. A detailed outline of each phase of the interview process is located in Appendix D.

The first phase of the interview was used to confirm demographic information collected during the phone interview and gather additional demographic data relevant to each counselor's training content areas, practice and supervision experience, and counseling orientation. The interview began by confirming the educational degree and date of graduation that form the basis of the individual's professional qualifications. Data concerning additional credentials, practice setting, length of professional service and the counties served by the counselor were also collected at the beginning of phase one. The interviewer then proceeded to collect more detailed information concerning training content areas contained within the counselor's masters program and inquired about professional training that participants had engaged in beyond the master's degree. The first phase of the interview concluded with several questions about the participant's supervision experience and theoretical orientation.

During phase two of the interview, participants were asked to review one client case in they had encountered boundaries of competency concerns during the course of treatment. Participants were invited to make their case review selection from their professional counseling experience in the practice of individual therapy. After the case was selected, participants were asked to tell the story of their process with the selected client. Participants were asked to begin their stories at the point they remembered becoming aware of the boundaries of competence concern and continue through either the decision to continue treatment or terminate and refer.

The third phase of the interview involved creation of a conceptual map based on the information generated in phase two. During this phase, participants were asked to review the interviewer's notations. The participant was then guided through the three-step process required to complete a conceptual map illustrating her or his ethical decision-making process in relation to the chosen clinical case.

The final or fourth phase was seen as the wrap-up phase. In this phase participants were invited to make additional comments about their process with the selected case and allowed time for observations concerning the conceptual mapping task. Phase four also included opportunity for the interviewer to further explore the interviewee's process of ethical decision making. As an unstructured interview phase in this otherwise structured interview process, the final interview phase was designed to "provide latitude to explore the responses of participants and to adapt question[s] for respondents" (Heppner, Kivlighan, & Wampold, 1999, p. 259).

PROCEDURES

The procedures for data collection in this study included participant selection and administration of the CMT interview instrument. Participant selection began by sending an initial letter of invitation for participant involvement to a random sample of individuals drawn for the Illinois LPC and LCPC lists. The initial recruitment information was sent to 375 LPCs and 375 LCPCs. However, 53 of the 750 letters of invitation were returned as undeliverable. Of the 697 counselors who received

invitations to participate, 33 responded, indicating interest in participating in the study. Of the 33 who indicated interest in the study, 20 were LPCs and 13 were LCPCs.

Eighteen of the 33 counselors who responded to the letter of invitation were screened in a short phone interview. A copy of the information and recruitment flyer and response post card can be found in Appendix A. Selection for the phone interview was determined by order of received response combined with consideration given to diversity (i.e., gender and geographical location) within the selection of participants. At the end of the phone interview, an appointment for administration of the four-phase interview was scheduled with the 14 respondents who met the research criteria and best satisfied the needs of the study at the time of the phone interview. A list of potential participants was maintained until all data was collected for purposes of continued selection.

Participant Selection

Potential participants were recruited from the state of Illinois list of active LPCs and LCPCs. The LPC and LCPC lists used in this study were purchased from the Illinois Department of Professional Regulation[1] in March of 2004. The list included only active LPCs and LCPCs. Indication of disciplinary action designator is available and was requested for this study. The list of potential participants selected was based upon systematically matching counselor location by zip code between the Illinois lists of active LPCs and LCPCs and a list of designated zip codes in Illinois.

[1] Illinois Department of Professional Regulation, 320 W. Washington 3rd Floor, Springfield, IL 62786.

The selected 375 LPCs and 375 LCPCs were sent an initial mailing of information and recruitment. Eighteen of the 33 counselors who indicated interest in the study were screened for participation in the four-phase interview through a short phone interview. The phone interview was designed to screen participants based upon the criteria for participant selection detailed earlier in this chapter.

Zip Code Selection Process

The list of zip codes was generated using the ZIPFind® computer program, purchased via the Internet[2]. The ZIPFind® program was used to select all Illinois zip codes located within a 100-mile radius of Geneva, Illinois (zip code number 60134). Both metropolitan and rural population samples were found within this geographical area The list generated contained a total of 533 populated[3] zip codes, and was organized according to mileage distance beginning at the center point (i.e., Geneva, Illinois) and ending with the zip codes most distant from the center within the 100-mile-radius criterion.

Recruitment and Selection of Counselors

The first step in the selection process was mailing an information and

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[2] ZipFind Central is available from Bridger-Systems, Inc. (copyright 1996-2000). Retrieved from http://www.link.usa.com/zipcode/

[3] There are a number of zip codes within 100 miles of Geneva, Illinois that are listed as zero population. These zip codes are generally corporate postal zip codes (personal conversation with a ZIPFind® customer service representative March 1, 2002).

recruitment flyer to potential participants. The information and recruitment flyer invited the selected counselors to indicate their initial interest either by return post card, phone, or email. Potential participants were selected to receive the information and recruitment flyer through a systematic process of matching counselors from the LPC and LCPC lists with 533 populated zip codes generated during the zip code selection process using the ZIPFind® program.

The selection of potential participants began with identifying the fifth zip code number on the generated zip code list. The order of counselors on both the LCP and LCPC lists were arranged alphabetically for each zip code in the state. The LPC and LCPC lists used for this study were organized in zip code order. Using counselor name lists obtained from the Illinois Department of Professional Regulation, having removed those professional counselors with a disciplinary action indicator, I selected the first five LPCs and the first five LCPCs whose zip code address matched this first selected zip code. The process was continued in like manner for every fifth zip code until 375 counselors were selected from each list.

It should be noted that some of the rural zip codes within the state of Illinois did not contain the minimum of five LPCs or LCPCs to form a grouping. When a selected zip code did not contain five LPCs and/or LCPCs, counselors from the zip code immediately following the originally designated zip were selected to complete the group of five. In those situations where the zip code following the selected zip code did not contain enough LPCs or LCPCs to fill out a group of five counselors, I continued down the list in zip code order until a group of five was formed. In every

case the counselors for a given zip code were selected in the order they appeared on the Illinois Department of Regulation list. When selection of each group of five counselors was completed, I moved to the fifth zip code following the last used zip code to begin the selection process for the next group of counselors. As the process continued, it was expected that the grouping of LPCs and LCPCs would not produce identical zip codes usage lists. It should be noted that I had to circle back to the beginning of the list in order to select the designated 375 counselors for the initial information and recruitment mailing. The selection process was designed to enhance the probability of variance between counselors serving metropolitan and rural populations.

Phone-Screening Interview

The second step in the selection process was the phone-screening interview. As counselor responses were received, I set up and conducted a 15-minute to 20-minute phone interview with selected respondents to screen potential participants for the face-to-face four-phase interview. The phone interview outline format can be found in Appendix B. Once it was determined that the potential participants met the criteria established for the study, as outlined earlier in this chapter, I used the grid, found at the end of Appendix B, to assist in the selection for variance in gender and location, and the demonstration of a verbally reflective communication style. The verbal reflective indicator was based upon the response given to the experience and style question within the phone interview. A plus sign indicated that the individual was

experienced as reflective and a negative sign indicated that the individual was not experienced as reflective.

The potential participants who met the criteria and needs of the study at the time of the interview, and were interested in continuing participation, were scheduled for a face-to-face interview at the end of the phone interview. I offered to meet selected participants at their place of employment. At the time an appointment was set further information was given concerning the face-to-face four-phase interview. Each participant was read the following three statements:

1. The face-to-face interview will take no more than one and one–half hours of your time.
2. You will be asked to sign a consent form as a research participant that will include your permission for the full interview to be audio-taped.
3. The research data will be reported in a manner that will protect your identity and the confidentiality of your client.

A copy of the consent form can be found in Appendix C.

In accordance with grounded theory, "constant comparative method of qualitative analysis methodology" (Glaser & Strauss, 1967), selection for face-to-face interviews continued until the data began to repeat itself. A total of 14 interviews were conducted for this study. The initial proposal for this study stated that data collection would not be terminated until a minimum of 6 LPC and 6 LCPC interviews had been completed. After the minimum number of interviews were completed, it was felt that

further interviews were needed. An additional LPC and LCPC were selected from the returned invitation cards. Following these two interviews, I, using the grounded theory, constant analysis method (Glaser & Strauss), concluded that theoretical saturation had been reached, and data collection was terminated.

Conceptual Mapping Interview

After the consent form was signed, the first phase of the interview began. I tape-recorded the entire interview from the point the consent form was signed.

During phase one, I worked to build rapport with participants while asking preset questions to gather information about basic professional education, continuing education endeavors, professional experience, and theoretical orientation. The literature indicates that training, experience and counselor orientation can affect the ethical decision-making process (Cottone & Claus, 2000). This structured information-gathering time served not only to build rapport leading into the conceptual mapping task, but also served the purpose of gathering basic factual data that informed the data analysis process. A complete outline for the four-phase conceptual mapping interview can be found in Appendix D.

During the second phase of the interview, the participant was asked to select one client situation she or he encountered while conducting individual counseling that raised concerns regarding boundaries of competence during the treatment process. The question was stated as follows:

> I would like you to think of one client case where, in the course of doing individual treatment, you became aware that you had just heard or had been

> hearing a client concern that was outside of your experience and/or training level.

The participant was then encouraged to give a very brief overview of the selected case.

After this very brief overview, the participant was asked to tell the story of her or his decision-making process. The following instruction was given:

> I would like to ask you to tell me the full story of your journey to resolve the concern you had with this client. I would like you to begin at the point you first became aware of your limits to treat this client and continue your story through the process of continued treatment or the termination and/or referral of this particular client.

The participant was then given extended time to delineate his or her own process with this selected client situation. During this time, the interviewer recorded participant responses on 1 and 7/8 by 2 and 7/8 inch Post-it® notes. Once interviewees had concluded their stories, they were shown the interviewer's records on the Post-it® notes and asked to review them. The interviewer checked with the participant to insure accuracy of listening and recording of the participant's case review.

During the third phase of the interview, interviewees were asked to create a conceptual map using the Post-it® notes generated during the second phase of the interview. Participants were given a large lap-board containing a 24 by 22 inch sheet of newsprint and asked to arrange the Post-it® notes into a conceptual map showing how the concepts were related. This was done in three steps:

1. Participants were asked to take Post-it® notes generated during the second phase and arrange them into a spatial representation of their process.
2. After the Post-it® notes were arranged on the board, participants were asked to draw lines connecting the concepts and/or demonstrating the flow of the

process they described. Participants were encouraged to indicate the flow of the process by use of arrow points on the lines or by some other means they felt clearly communicated directional movement of the process.

3. The final step in creating the conceptual map involved asking participants to draw a circle around each group of concepts they perceived belonging together. Clusters of concepts were then formed. Participants were then asked to label each cluster.

I remained silent while participants took the time they needed to arrange the notes into a spatial representation, drawing flow lines, and forming and labeling clusters.

The forth and final phase of the interview followed the unstructured interview format (Heppner, Kivlighan, & Wampold, 1999). At this point in the interview I provided time for participants to reflect on their experience of the CMT and were invited to offer any final observations or thoughts. During this phase of the interview I would, if necessary, make further inquiry concerning participant conceptual maps and the process of decision making, in order to explore further clarification or insight.

This portion of the fourth phase gave opportunity for me to explore any emerging but incomplete issues from phases two and three. The goal of this exploration was to seek clarification of concepts presented by the participant in the case presentation or creation of the conceptual map. Because it was not possible to know what would need to be explored by the participants or interviewer prior to the completion of phases one, two, and three, this final phase followed the unstructured interview format. There were

only two pre-identified questions and a closing statement outlined for the interviewer in the interview protocol. The two pre-set questions were:

1. Do you have any reactions to the conceptual mapping task that you would like to share?
2. Is there anything you want to add to the ideas you have already shared?

The final phase ended with the following statement containing final information about reporting of the data and a word of thanks from me:

> I am very grateful for your participation in this study and appreciate your sharing your story with me. I want to say again that the data we have recorded via audio-tape and on this large piece of paper will be reported in a way that protects your privacy and the confidentiality of your client. The reporting of the data will be about your process and not about your particular client. If at any time in the coming weeks, you become concerned about this matter, please feel free to contact me. On the consent form you have indicated your interest in reading the data presentation before it goes into final form and I want you to know that I will respect your request. Again, thank you for your participation and giving me the privilege of hearing your story.

Data Analysis

Each interview was transcribed and analyzed along with the conceptual maps for themes and emerging concepts in ethical decision making. Given that the Post-it® notes had a tendency to shift on the newsprint sheets, each conceptual map was laminated prior to data analysis to insure accuracy of data retention and for ease in handling during the analysis process. Both the interviews and the conceptual maps were studied as they were collected in order to inform me in relation to the continued participant selection requirement and to make needed interview adjustments. During the process of constant comparative analysis, I worked to "stretch diversity of data as

far as possible" (Glaser & Strauss, 1967, p. 61), and when I noticed themes repeating themselves (Glaser & Strauss) it was concluded that theoretical saturation had been reached.

The material gathered also was analyzed for similarities and differences between novice and experienced therapists, as well as similarities and differences among other themes that emerged during the data collection. Finally, the entire body of data was compared to current models of ethical decision-making found in the literature.

I used the comparative method steps outlined by Glaser and Strauss (1967) in the analysis. The first step was to create categories based on the concepts and incidents reported by participants. As successive participant conceptual maps and transcripts were analyzed, I compared the incidents for inclusion in the existing categories and new categories, and/or created sub, sub-sub, and sub-sub-sub categories as they emerged within existing categories. The second step involved integrating the categories and their subcategories through the constant comparison of data. The third step involved the delimiting of the theory or in this case the research-based emergent model.

Glaser and Strauss (1967) indicated that in using the constant comparative method the "coding, and analyzing of incidents can become more select and focused" (p. 111). According to Glaser and Strauss, this focus leads to a reduction process that will in turn generate insights necessary to assess when categories have become theoretically saturated. The fourth and final step in generating theory is that of writing the theory or, for purposes of this study, forming the model for ethical decision

making. The emergence of a research-based model addresses the first research question proposed for this study.

The second and third questions in this study were concerned with a comparison of the novice and experienced counselor in both the decision-making process and the implementation of the decision when confronted with ethical dilemmas around limits of practice concerns. In addressing these two questions I again used the comparative analysis method to discover the similarities and differences between the two comparative groups and reported the data did not answer these questions.

The final research question proposed for this study asked for a comparison of the findings and the models for ethical decision-making currently found in the literature. While Glaser and Strauss warn the researcher against being "'hooked' on verifying" (p. 28) existing theory, they also suggested that the researcher will naturally create categories that have parallels in the literature. In addressing question four I used caution in the comparative analysis process. The goal was to be informed by, but not led by, the literature.

RESEARCH QUESTIONS

1. What ethical decision-making model emerges from the data as professional counselors outline the process they follow to resolve boundaries of competency concerns?

2. What are the similarities and differences that emerge between the novice (LPC) and experienced (LCPC) counselor as they engage in the ethical decision-making process as it relates to a boundaries of competency concern?
3. Once a decision has been made to continue to treat or to refer, how does the practicing professional counselor implement the decision, and what are the similarities and differences between the novice and experienced counselors' approach to decision implementation?
4. How does the ethical decision-making process of the practicing professional counselor compare with the ethical decision-making models currently found in the literature?

CHAPTER 4

FINDINGS: OVERVIEW OF PARTICIPANTS

The purpose of this qualitative grounded theory research study was to explore the ethical decision-making process practicing professional counselors engage in when they are confronted with boundary of competence concerns within ongoing individual counseling relationships. The study included 14 qualitative interviews. The first contact with the participants was by an invitation they received via regular mail. The invitations were sent to 750 licensed counselors in the state of Illinois. The initial 750 were randomly selected from a list of all licensed counselors in the state of Illinois. Counselors who responded to the invitation to participate in the study were screened by phone in order of response with some consideration given to variance of geographical location. Fourteen participants were invited to participate in the four-phase face-to-face interview. Face-to-face interviews were audio taped, transcribed, and then analyzed for emergent categories. Each transcript was read and reread numerous times. As categories, their sub and sub-sub-categories emerged during the analysis, they were organized and compiled for written report.

Discussion of the participants begins with a brief section concerning changes in protocol following the review of participants. The changes in protocol deal with redefining the experience and novice groupings based on years of experience rather than the anticipated license status differentiation. Following the changes in protocol

section the discussion of the findings for this study proceeds with a review of the 14 participants. The review of participants begins with a presentation of aggregate demographic data and concludes with individual participant profiles. Analysis of data is presented in Chapter 5.

CHANGES IN PROTOCOL

Two of the research questions for this study asked for a comparison of novice and experienced counselors in regard to decision-making approach. The novice and experienced counselors were originally thought to be differentiated by level of license, with novice counselors being LPCs and experienced counselors being the LCPCs. However, during the course of the face-to-face interviews, it became apparent that license level is not an accurate measure for distinguishing novice and experienced counselors.

The demographic data shows a decisive difference in experience among participants in both the LPC and LCPC groups. It was unanticipated that LPC participants would have extensive experience or that LCPCs would have minimal experience. It was found that two of the LPCs had extensive professional counseling experience and two of the LCPC participants had become LCPCs only shortly before the initial invitations to participate in the study had been mailed, and had minimal experience in the professional counselor role.

Within the LPC group, two participants, Bob and Susan, each had a significant number of years and experience working as professional counselors. At the time of the

interview Bob reported 12 years of full-time and one year of part-time clinical experience providing counseling to populations with severe mental health concerns but did not have the course work necessary to sit for the LCPC exam. Susan indicated that as a career counselor in her current position, she feels no need to become an LCPC but has eighteen years of full-time and three years part-time experience in career counseling.

Within the LCPC group, two counselors, Matthew and Sarah, have minimal work experience as professional counselors. Matthew had barely more than two years of full-time experience and Sarah reported practicing a few hours a week in the two years since earning her master's degree.

Consequently, it was decided that the measure distinguishing novice and experienced counselor identity for this study needed to be changed to more accurately reflect the profiles of the participants. It quickly became apparent that years of professional experience was a more accurate indicator of novice and experience identity for this study then licensure level. In the area of credentialing, one measure of the experienced counselor is consideration of the status of supervisor. According to the Center for Credentialing and Education (2006), the requirements for the Approved Clinical Supervisor (ACS) credential, which is recognized by the National Board of Certified Counselors (NBCC), include a "minimum of three years of post-master's degree experience in mental health services, with a minimum of 1,500 hours direct service with clients" (p.1).

Using this standard for ACS credentialing as a guideline, it was determined that participants who had less than the equivalent of three years of full-time professional counseling experience would be identified as novice counselors, and those participants who have the equivalent of more than three years of full-time professional counseling experience are identified as experienced counselors. Neither Matthew nor Sarah, as LCPCs, reported experience that would meet these standards for experienced counselors. Both Bob and Susan, as LPCs, did report experience which would far exceed these criteria for experienced counselors. All of the remaining LPCs reported experience that is clearly below this standard for practice experience. With the exception of Matthew and Sarah, each of the LCPCs reported experience fitting the ACS years of experience criteria. Therefore, the novice counselor group contains seven participants with five being LPCs and two being LCPCs. The remaining seven participants fall into the experienced counselor group with five being LCPCs and two being LPCs.

PARTICIPANTS

Aggregate Demographic Data

During the phone screening and phase one of the four-phase face-to-face interviews, basic demographic information was collected for each participant. Fourteen participants were selected for face-to-face interviews. Participants were equally divided between the two levels of licensure for professional counselors in the State of Illinois. The two levels of licensure are Licensed Professional Counselor

(LPC) or entry level and Licensed Clinical Professional Counselor (LCPC), the advanced clinical level of counselor licensure in the state of Illinois. Nine participants are female and five are male. Within the LPC group four participants are female and three are male. Within the LCPC group five are female and two are male. One of the participants is African American, one is Latina, and twelve are Euro-American.

The following aggregate data is presented using novice and experienced grouping of participants. The novice and experienced counselor groupings are not designated according to level of licensure but are differentiated by years of reported experience as professional counselors. Novice counselors are those who reported less than the equivalent of three years of full-time work as professional counselors. Participants who reported the equivalent of more than three years of professional counseling work were placed in the experienced counselor group. Both the novice and experienced counselor groups contain seven participants. Within the novice counselor group four are female and three are male. Within the experienced counselor group five are female and two are male.

Education, Credentials, and Experience

Professional Degree Type and Dates

All participants hold a master's degree, which is required for licensure in the state of Illinois. One of the participants was engaged in doctoral-level studies in counseling at the time of the interview and a second reported having previously done a minimal amount of doctoral-level study in psychology. Participants reported holding

degrees in several disciplines. Eight of the participants hold degrees in counseling from education departments, with two of these referring to their degrees as being in counseling and guidance. Three hold degrees in counseling psychology. Three hold degrees in some discipline other than counseling or counseling psychology. Table 18 lists frequency of degree type.

Table 18

Frequency of Degree Type by Novice and Experienced Counselors

	Degree Type		
	Counseling	Counseling Psychology	Other
Novice	3	2	1
Experienced	5	1	2
Totals	8	3	3

The three participants holding degree type "other" as identified in Table 18 include one in education, one in pastoral counseling, and one in health science. The participant holding the pastoral counseling degree is in the novice grouping and the participants holding the education and health science degrees are in the experienced grouping.

The participant degree completion dates range from 1966 to 2002. The novice counselor degree completion dates range form 1997 to 2002, and the experienced

counselor degree completion dates range form 1966 to 1998. Table 19 lists frequency of graduation date.

Table 19

Frequency of Graduation Date by Novice and Experienced Counselors

	Dates		
	1966 to 1989	1990 to 1999	2000 to 2002
Novice	0	4	3
Experienced	3	4	0
Totals	3	8	3

Degree Training Content Areas

During phase one of the face-to-face interviews each participant was asked about training and course work within their master's degree training. As each training content area was named, participants were asked to indicate if the named content area was part of their master's degree training. If they indicated the training content was part of their degree training, they were asked to give a helpfulness ranking of the content area in relation to their practice of professional counseling.

The ranking of course content areas was on a 5-point scale with 1 being the lowest or not helpful, 3 being somewhat helpful, and 5 being the highest or very helpful. The frequency of training content areas within professional degree program

training is listed in Tables 20, 21, and 22. Novice counselor frequencies are in Table 20, experienced counselor frequencies are in Table 21, and frequency totals for both groups are listed in Table 22. Because the participants were given a 5-point scale but encouraged to rank course content based on the three prompts of helpful, somewhat helpful, and not helpful, the frequency data listed in the tables is given according to those three prompts. A ranking of 4 or 5 is reported as helpful. A ranking of 3 is reported as somewhat helpful, and a ranking 1 or 2 is reported as not helpful. These divisions were decided upon after comparing the ranking numbers with the comments of the participants. Some participants did not receive training in all content areas within their professional degree programs. Totals reported in Tables 20, 21, and 22 reflect this variance in number of participants who reported particular professional degree training content areas.

Although the participants were not asked to indicate if the content area was a course or infused into the curriculum, two responded as if they had been asked to make this distinction in regard to ethics. Both of these participants, one a novice and the other an experienced counselor, scored ethics content as a 2. The novice counselor said "I'd rate it as a 2 because it should have been a course." The experienced counselor stated, "It wasn't a course, but it was covered in coursework. I would say [it was] not a big emphasis so [I'd give it] a 2."

Table 20

Frequency of Usefulness Rating for Training Content Areas within Professional Degree Program by Novice Counselors

	Novice Counselors			
	Helpful	Somewhat Helpful	Not Helpful	Total Novice Counselors Reporting Content Area
Legal & Prof. Issues	3	2	0	5
Ethics	5	1	1	7
Skills/Techniques	5	2	0	7
Theory	5	2	0	7
Marriage/ Family	5	2	0	7
Group	7	0	0	7
Diagnosis/DSM	6	0	0	6
Addictions	3	2	0	5
Testing & Assessment	3	2	1	6
Multi-cultural	4	2	0	6
Career	4	1	1	6
Practicum	7	0	0	7
Internship	7	0	0	7

Ranking was 1-5: Helpful = 4 or 5, Somewhat Helpful = 3, Not Helpful = 1 or 2

Table 21

Frequency of Usefulness Rating for Training Content Areas within Professional Degree Program by Experienced Counselors

	Experienced Counselors			
	Helpful	Somewhat Helpful	Not Helpful	Total Experienced Counselors Reporting Content Area
Legal & Prof. Issues	4	0	2	6
Ethics	3	3	1	7
Skills/Techniques	5	1	0	6
Theory	4	0	1	5
Marriage/ Family	3	0	1	4
Group	1	3	0	4
Diagnosis/DSM	3	0	0	3
Addictions	2	0	0	2
Testing & Assessment	2	2	2	6
Multi-cultural	5	0	0	5
Career	1	0	1	2
Practicum	5	1	1	7
Internship	3	1	0	4

Ranking was 1-5: Helpful = 4 or 5, Somewhat Helpful = 3, Not Helpful = 1 or 2

Table 22

Frequency Totals of Usefulness Rating for Training Content Areas within Professional Degree Program by Novice and Experienced Counselors

	Total: Novice and Experienced Counselors Ranking Training Content Area			
	Helpful	Somewhat Helpful	Not Helpful	Total Counselors Reporting Content Area
Legal & Prof. Issues	7	2	2	11
Ethics	8	4	2	14
Skills/Techniques	10	3	0	13
Theory	9	2	1	12
Marriage/ Family	8	2	1	11
Group	8	3	0	11
Diagnosis/DSM	9	0	0	9
Addictions	5	2	0	7
Testing & Assessment	5	4	3	12
Multi-cultural	9	2	0	11
Career	5	1	2	8
Practicum	12	1	1	14
Internship	10	1	0	11

Ranking was 1-5: Helpful = 4 or 5, Somewhat Helpful = 3, Not Helpful = 1 or 2

Continuing Education Content Areas

Following the inquiry concerning course work within their master's training, participants were asked to indicate training they had engaged in beyond their master's degree including further formal academic training, independent reading, seminars, or workshops. Participants were again asked to rank the usefulness of specific content areas using the same scale they had for the professional degree training content areas. The frequency of usefulness ranking of continuing education content areas is listed in Tables 23, 24, and 25. The data in Tables 23, 24, and 25 are reported in the same manner as in the professional degree training content area tables. Novice counselor frequencies are listed in Table 23, experienced counselor frequencies are listed in Table 24, and frequency totals for reported continuing education endeavors for both groups are listed in Table 25. Not all participants participated in all content areas.

Participants were also asked to list areas of continuing education study that were not mentioned as specific areas for rating. All but one participant listed additional areas of study. Continuing education areas of study mentioned were grief and loss, gang specialty, assessment and treatment of sexual offenders, divorce mediation, crisis work, coaching, non-violent communication, Eye Movement Desensitization and Reprocessing (EMDR), guided imagery, dream work, attachment theory, adolescents, domestic violence, psychopharmacology, treating borderline personality disorders, hypnotherapy, and agency accreditation.

Table 23

Frequency of Usefulness Rating for Continuing Education Content Areas by Novice Counselors

	Novice Counselors			
	Helpful	Somewhat Helpful	Not Helpful	Total Counselors Reporting Content Area
Legal, Ethical & Prof. Issues	2	1	0	3
Skills/Techniques	2	0	1	3
Theory	1	0	0	1
Marriage/ Family	3	0	0	3
Group	4	0	0	4
Diagnosis/DSM	3	1	0	4
Addictions	4	0	0	4
Testing & Assessment	1	1	0	2
Multi-cultural	3	0	0	3
Career	1	0	0	1

Ranking was 1-5 scale: Helpful = 4 or 5, Somewhat Helpful = 3, Not Helpful = 1 or 2

Table 24

Frequency of Usefulness Rating for Continuing Education Content Areas by Experienced Counselors

	Experienced Counselors			
	Helpful	Somewhat Helpful	Not Helpful	Total Experienced Counselors Reporting Content Area
Legal, Ethical & Prof. Issues	4	0	0	4
Skills/Techniques	5	1	0	6
Theory	1	3	1	5
Marriage/ Family	6	0	0	6
Group	2	2	0	4
Diagnosis/DSM	3	1	1	5
Addictions	2	1	0	3
Testing & Assessment	1	0	0	1
Multi-cultural	5	1	0	6
Career	1	0	1	2

Ranking was 1-5 scale: Helpful = 4 or 5, Somewhat Helpful = 3, Not Helpful = 1 or 2

Table 25

Frequency Totals of Usefulness Rating for Continuing Education Content Areas by Novice and Experienced Counselors

	Totals for Novice and Experienced Counselors			
	Helpful	Somewhat Helpful	Not Helpful	Total Counselors Reporting Content Area
Legal, Ethical & Prof. Issues	6	1	0	7
Skills/Techniques	7	1	1	9
Theory	2	3	1	6
Marriage/ Family	9	0	0	9
Group	6	2	0	8
Diagnosis/DSM	6	2	1	9
Addictions	6	1	0	7
Testing & Assessment	2	1	0	3
Multi-cultural	8	1	0	9
Career	2	0	1	3

Ranking was 1-5 scale: Helpful = 4 or 5, Somewhat Helpful = 3, Not Helpful = 1 or 2

Seven of the participants indicated that a portion of their continuing education endeavors were through independent study. Each of these individuals specified some clinical need or personal interest that propelled them to pursue a given area of study through independent reading. Participants spoke positively of the clinical and personal benefits when identifying their independent study.

License and Certifications

During the phone screening interviews potential participants were asked about the license(s) they held that enabled them to practice as a mental health professional. Inquiry was also made as to what other professional credential(s) they held. The responses to these questions are listed in Table 26.

Table 26

Frequency of Professional Credentials

	Professional Certifications			
	LPC	LCPC	NCC[1]	Other
Novice	5	2	2	3
Experienced	2	5	4	3
Totals	7	7	6	6

[1] NCC refers to the National Certified Counselor credential that is obtained through the National Board of Certified Counselors.

The participants all held professional counselor licenses. Within the novice counselor grouping, five of counselors were LPCs and two were the LCPCs. Within the experienced counselor group, two of the counselors were LPCs and five were LCPCs.

The National Certified Counselor (NCC) credential, which is obtained through the National Board of Certified Counselors, was held by six of the participants. Within the novice counselor grouping two of the counselors held this credential. The experienced counselor group contained four participants who held the NCC credential.

The "other" column in Table 26 refers to a variety of credentials related to the practice of professional counseling other than their counselor license or the NCC credential. There are six participants counselors in this column. Three novice counselors and three experienced counselors reported in the "other" category. One of the novice counselors reported holding a Psycho-Social Rehabilitation Certification, another indicated certification as a Hypnotherapist as well as a Neuro Linguistic Programming certification, and the third reported holding the Certified Alcohol and Drug Counselor (CADC) credential. Of the three experienced counselors reporting credentials in the "other" category, one reported three certifications in career counseling including the National Certified Career Counselor (NCCC), the Master Career Counselor, and the Certified Instructor for Career Development. Another experienced counselor reported holding three credentials in addictions including the CADC, the Master Addictions Counselor certification (MAC), and a credential in Dual Diagnosis as well as a credential in bereavement. The third experienced

counselor in the "other" column reported being a Registered Nurse and indicated that this training and experience informed her work.

Practice Settings and Experience

Practice setting structure. During the phone interview the participants were asked to list the setting or settings they had worked in as professional counselors. Table 27 lists the reported past and current settings by novice and experienced groupings.

Novice participants reported a range of work experiences. Only one of these participants reported post degree work in addition to her current setting and those positions were in career testing in both academic and a private not-for-profit setting doing career testing. Within the novice grouping, four participants reported working in community agency settings at the time of the interview. These settings were reported as work with "residential and outpatient severe adult mental illness," vocational rehabilitation, bereavement in a hospice setting, and group work with adolescents. Three of the novice participants reported doing private practice work. Two of these were LCPCs and one was an LPC who was working in a group practice. Of the two LCPCs in private practice, one was just beginning a private practice while still working in an agency setting and the other reported having done private practice part-time for two years.

Table *27*

Frequency of Participant Practice Settings by Novice and Experienced Counselors

	Community Agency	Hospital	Academic Higher Ed	Private Practice	Other
		Novice			
Current Setting(s)	4			3	1
Past Settings			1		1
		Experienced			
Current Setting(s)	3	1	1	4	
Past Settings	4	2			1
		Totals			
Current Setting	7	1	1	7	1
Past Settings	4	2	1		2
Total: Current and Past Settings	11	3	2	7	3

The experienced counselors reported working in a variety of settings. Four of the experienced counselors reported working in private practice, with two of these participants doing only private practice work at the time of the interview. Three of the group reported working in community agency settings at the time of the interview, with two of these also working in private practice. One of the participants was working in a hospital setting at the time of the interview and one was in higher education. The experienced participant group reported a wide breadth of past experience, including community agency work involving inpatient, partial hospitalization, career-related counseling, crisis work, with some combination of children, adolescent, adult and elderly populations. The other category of past settings involves corporate career development work.

Rural or urban. During the first phase of the four-phase face-to-face interview participants were read the following statement and then asked to identify the county in the state of Illinois from which they drew their clients:

> As a researcher, I am interested in the difference in dynamics that might emerge for therapists who serve clients from differing geographical areas such as rural and metropolitan population centers. In this study this distinction will be determined based upon the US Census Bureau map that indicates which counties in the state of Illinois are to be considered rural and which are to be considered metropolitan.

None of the participants identified counties which are considered rural according to the US Census Bureau map. After the counties were identified, the participants were asked, "If they needed to refer a client to another agency or counselor, would this create a logistical hardship for your clients?" When answering this question, three of the participants expressed concern that client location, available services for special

needs, economics and/or transportation considerations at times made alternative services impossible for their clients to access, and therefore, at times prohibited referral options.

Years of Experience. During the phone screening interview potential participants were asked about their full-time and part-time years of experience doing clinical work. The frequency of full-time and part-time years of clinical experience reported by novice and experienced counselors at the time of the interview is listed in Table 28. The novice counselors all have the equivalent of less than three years of full-time experience. The experienced counselors have a range of five to twenty years of experience, with all of that being reported as full-time.

Supervision

During the four-phase face-to-face interview participants were asked how frequently they attend individual and/or group supervision. Table 29 lists the frequency of individual and group supervision attendance at the time of the interview. At this point in the interview participants were also asked to rank the helpfulness of their current supervision experience. All participants reported attending some form of supervision at least one time a month.

Table 28

Frequency of Full and Part-Time Years of Clinical Experience for Novice and Experienced Counselors

	Years of Experience			
	Less than 3	5 – 10	11 – 15	15-20
	Novice Counselors			
Full Time	4			
Part Time	3			
	Experienced Counselors			
Full Time		3	1	3
Part Time				

Table 29

Frequency of Supervision Attendance by Novice and Experienced Counselors

	Individual Supervision				
	Weekly	Twice a month	Monthly	As Needed	Never
	Novice				
Individual	2	3	1		1
Group	3	1	2		1
	Experienced				
Individual		1		3	3
Group	1	3	1		2
	Totals				
Individual	2	4	1	3	4
Group	4	4	3		3

Within the novice counselor group all but one of the participants participated in individual supervision. Two of the participants reported attending individual supervision weekly, three twice a month, and one once a month. The novice counselor who reported never attending individual supervision reported attending group supervision "every six weeks or so." All but one of the novice counselors reported attending group supervision with three attending weekly, one attending twice a month, and two attending once a month. The one novice counselor who reported never attending group supervision reported attending individual supervision twice a month.

In the experienced counselor grouping no participants reported attending individual supervision on a weekly basis, one reported attending twice a month, three reported using individual supervision as needed, and three reported "never." All three of the experienced counselors who reported never attending individual supervision indicated attendance at group supervision twice a month. Two of these individuals referenced peer consultation as their primary means of seeking individual assistance when difficulties arise. Five of the experienced counselors indicated involvement in group supervision with one attending weekly, three twice a month, and one once monthly. Both of the participants in the experienced counselor group, who reported never attending group supervision, indicated they sought individual supervision as needed.

Because a number of the participants shared both past and current supervision experiences and mixed ratings for both into their supervision rating discussions, it was

difficult to be certain which experiences they were rating. Due to this mixing of discussion and rating for current and past supervision the rating data is not reportable.

Theory

At the end of phase one of the four-phase face-to-face interview, participants were asked to select and rank-order three theoretical orientations with which they most strongly identified in their clinical work. The participants were handed a checklist that included Psychoanalytic, Adlerian, Rogerian, Existential, Rational Emotive Behavioral Therapy (REBT), Solution Focused, Systemic, Jungian, Ego Psychology, Gestalt, Cognitive Behavioral, Feminist, and Narrative theoretical orientations. At the end of the list a space for "other" was provided in case a theory important to them was not listed. Participants were instructed to choose no more than three and rank-order them choosing number 1 as the most dominate in their work, 2 as the next dominate, and 3 for the third most dominate.

Table 30 lists the novice and experienced counselor theory preferences. Among the novice counselors two did not select a number three preference. Six counselors selected "other" as one of their theory preferences. Within the "other" category counselors indicated Transactional Analysis, Multi-Modal, Experiential Play Therapy, Expressive therapy, Krumboltz theory, and a rare type of hypnotherapy as part of their dominate theoretical preferences.

Table 30

Frequency of Theoretical Orientation Preferences for Novice and Experienced Counselors

	Novice Counselors Preferences			Experienced Counselors Preferences			Totals
	1st	2nd	3rd	1st	2nd	3rd	
Psychoanalytic			1				1
Ego Psychology		1					1
Adlerian			1	1	1	1	4
Jungian			1			1	2
Rogerian	2	1					3
Existential				1	1		2
Gestalt		2				1	3
Cognitive Behavioral	3	1		1	3		8
REBT							0
Solution focused	1	1	1	1		1	5
Systemic			1	1	1		3
Feminist						1	1
Narrative						1	1
Other	1	1		2	1	1	6

Individual Profiles

Each participant profile is divided into two sections. The first section presents a brief background snapshot of participants including gender, race, life stage, degree relevant to the practice of professional counseling, professional credentials, and a brief overview of relevant professional experience including geographical location and referral considerations. The second section describes each participant's conceptual mapping task (CMT) process. The CMT discussion includes an overview of the client case selection process and a description of the participant's conceptual map that is coupled with a computerized duplication of the each conceptual map. Names used in describing each participant and their clients selected for the CMT are pseudonyms assigned by participants. Some of the details shared by the participants are reported in an intentionally vague manner in an effort to protect identities of all parties involved. Some data such as gender, age, and diagnosis of clients have been carefully altered to protect confidentiality and yet preserve the dynamic of the ethical decision-making processes described by participants. Individual participant profiles are presented in the order in which they were interviewed.

The client selection process was introduced at the beginning of phase two of the face-to-face interview when each participant was presented with the following task:

> I would like you to think of one client case where, in the course of doing individual treatment, you became aware that you had just heard or had been hearing a client concern that was outside of your experience and/or training level.

Upon completing the client selection process, each participant was invited to tell the story of the selected case situation using the following instructions:

> I would like to ask you to take about 15 minutes to tell me the full story of your journey to resolve the concern you had with this client. I would like you to begin at the point you first became aware of your limits to treat this client and continue your story through the process of continued treatment, the termination, and/or referral of this particular client.

After participants selected a client case and told their story, they were introduced to the conceptual mapping task. The researcher had recorded the details of each participant's story on Post-it® notes, and, at this point in the interview, participants were asked to review the Post-it® notes for accuracy and completeness. Post-it® notes were corrected and/or added to as participants directed. Participants then created their maps using the Post-it® notes.

There were four steps involved in creating the conceptual map. First, participants were given a large sheet of paper clipped to a lap-board and asked to arrange the Post-it® notes into a spatial representation of the process they had described in their story. Second, participants were asked to draw lines to connect concepts and/or demonstrate the flow of the process they had just described. Participants were given the following instructions concerning this step:

> Now that you have arranged the Post-it® notes on the board, I would like to ask you to draw lines that connect the concepts and/or demonstrate the flow of the process they have described. I would like to encourage you to indicate the flow of the process by use of arrow points on the lines or by some other means that you feel clearly communicates any directional movement within the process.

Third, participants were asked to study their maps and circle groups of concepts that emerged to form clusters of concepts. In the process of "circling the groups of

concepts" participants formed a number of geometric figures, such as rounded squares, rounded rectangles, circles, triangles, etc.

Fourth, participants were asked to label each of the concept clusters or content symbols they had created. Although each participant worked through all four steps, some reversed steps two and three, preferring to group clusters of ideas together before drawing flow lines, thus linking the content symbols rather than individual Post-it® notes. A full presentation of the conceptual mapping task can be found in Appendix D.

Each participant's conceptual map has been duplicated as closely as possible using a conceptual mapping computer program[1], and is located within the CMT sections of the individual profiles. The maps contain the geometric figures that summarize the clusters of concepts formed with the Post-it® notes in phase three of the face-to-face interview. These various geometric figures are referred to in the discussion sections as "content symbols." The labels and/or statements referencing the content symbols found on each map are italicized throughout this chapter. Referencing of content symbol labels, quoting of any extra writing on maps, and citing of individual Post-it® note content is done verbatim. Some of these items are not grammatically correct but have been duplicated as written in the interest of reporting accuracy. Lines and arrows designating the flow of the process participants described

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[1] Inspiration Software, Inc. version 7.5 is the program used in the data reporting and is located in Portland, OR. The web address for this software was found on the Internet at www.inspiration.com in November 2003. (1988-2003 Copyright)

are also duplicated and discussed. The novice and experienced counselor maps have been differentiated by use of shading. Content symbols within each novice counselor's map have been left white. The symbols within each experienced counselor's map are shown with gray shading.

Sarah: First Interview (Novice Counselor)

Background

Sarah is a Euro-American female in middle adulthood. She reported completing her master's degree in counseling psychology. In addition to being a Licensed Clinical Professional Counselor (LCPC), Sarah reported that she is a National Certified Counselor (NCC) and holds certification in hypnotherapy and Neuro Linguistic Programming.

Sarah reported her past professional experience as including part-time career counseling within government, academic, and private not-for-profit agency settings. At the time of the interview, Sarah was engaged in general mental health counseling in a private practice setting and selected her case for the CMT from her private practice setting. She reported having approximately two years of part-time clinical experience.

In regard to making ethical decisions, she indicated her current setting as a private practitioner gave her full freedom to work without limitations from any administrative structure. Her private practice is located in an urban area that might be more accurately described as suburban. She does not feel her geographical location would in any way limit her in making referrals. She stated, "To get out here, my

clients have to have access to a car . . . Actually, probably anybody I would make a referral to would be more convenient than me."

Conceptual Mapping Task

Client selection and case overview. At the beginning of phase two of the face-to-face interview participants were asked to select a client with whom they had faced a boundaries of competence dilemma during the course of individual treatment. Sarah quickly selected Carl. Sarah explained that she began to question her ability to provide therapy for Carl when he was unable to work well with the techniques she uses. However, she continued to work with him because, as she stated, "he kept coming back." As treatment progressed Sarah reported that she "tried varying what we did a little bit."

Sarah next began to implement a modality that she was learning in her extensive multiyear training program, but again, he did not respond to the technique according to protocol. These were experiential techniques and Sarah indicated she was not getting cues from Carl as to what was going on for him during the exercises. Under these conditions she did not feel she could proceed.

She then returned to using a technique with which she had previous experience. However, his responses or lack of them left Sarah concerned. Sarah stated, "I didn't know if he was doing the work or not" because the usual cues were missing. At this point she believed Carl needed to do work that would require intense physical expression. Although she was confident of her assessment and treatment plan, she

reported, "I just didn't have the physical capability. He needed group work." At this point she referred him to a colleague.

Sarah gave her rationale for referral and summary of treatment concerns when she stated,

> He had a lot of resistance to anything that we did in terms of really going to his emotions. He did some good work. I would have to say that he did some very good healing work through the process but I wasn't able to get down deep enough to really do what I felt would be the best healing work.

In the course of telling her story and reviewing her map Sarah did not mention seeking supervision. During phase four of the face-to-face interview, she was asked if she had specifically staffed Carl in her group supervision/education setting. She reported that she did not bring his case to the distance learning setting, but said "I did bring him up in my [local] supervision group." This group was directly connected to the larger distance learning program. Her report of that supervision experience was:

> I think they were telling me it's OK. What I was doing was OK. Some people do the whole thing in their head. I was trying to say, "He's not talking. He's not emoting. I'm not doing it right." And they were like, "No, he is on his journey."

Conceptual map description. The overarching descriptive word Sarah used to talk about her conceptual map was "spiral." Six numbered and labeled content symbols plus numerous flow lines make up Sarah's conceptual map. A computer duplication of her map is presented in Figure 3.

The center point for the Sarah's map is the long rectangle in the center of the map entitled *Back to the Issues* and indicated as the zero point. This content symbol contains Carl's stated presenting issues. Sarah said as she pointed to this rectangle that it contained the "issues that he brought [to therapy]. That's the center. So it starts

here." Later she stated that Carl was "actually using all these issues . . . to resist going to the core issues." It was this issue avoidance that Sarah was unable to break through and in part caused her to question her ability to really help Carl.

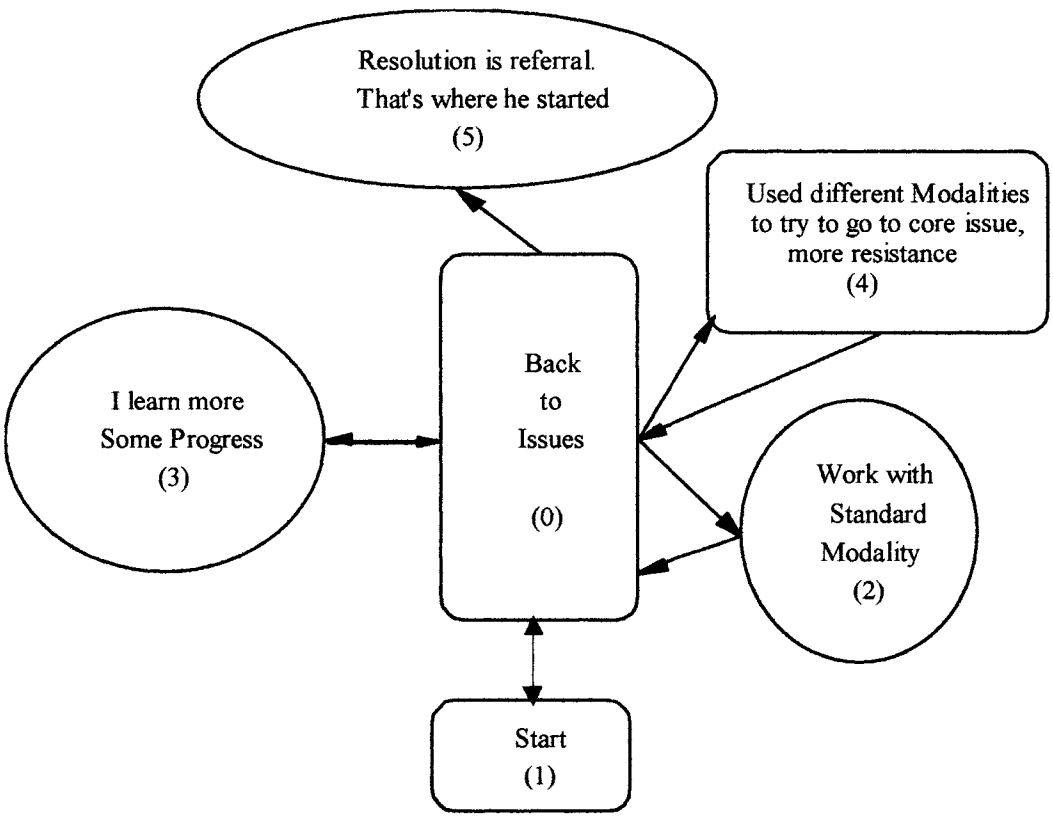


Figure 3. Conceptual map created by Sarah (Novice Counselor)

The remaining five content symbols include two more rectangles and three circular objects. The rectangle entitled *Start (1)* contains information about how Carl was referred to Sarah. The content symbols labeled *Work with Standard Modality (2), I learn more/Some Progress (3), and Used different modalities to try to go to core issues/more resistance (4)* contain a number of Post-it® notes describing the various intervention techniques she attempted to use with him during the course of his treatment with her and his responses to these interventions. The oval at the top and just to the left of center labeled *Resolution is referral/That's where he started (5)* represents the information in her story about the referral process. The title of the resolution oval may seem a bit odd, but is perhaps explained by insight Sarah gleaned after the referral was complete. The next counselor Carl engaged with shared with Sarah, in an off-handed comment, that "Carl loves to call therapists" and indicated that Carl might always be in and out of a therapy/referral cycle.

The flow lines, which move between the *Back to the Issues (0)* rectangle and the other symbols, demonstrate the interactive nature of Sarah's efforts to find satisfactory techniques and therapeutic understanding to assist her client in working through his concerns. The flow of the decision-making process, which is demonstrated by arrow points, indicates that all of her techniques variations (content symbols 2, 3, and 4) led back to the center rectangle. The final decision to refer is shown with an arrow leading out of the center rectangle and into the *Resolution is referral/that's where he started (5)* oval.

It is the flow lines and Sarah's verbal explanations of her map that give life to her concept of her process as a spiral. The spiral process of attending to issues and trying out new modalities is shown in the flow lines leading into and out of the center rectangle labeled *Back to the Issues (0)* that Sarah verbally referred to as "zero" or "home." At two different points Sarah referred to the "spiral" nature of her conceptual map. As she began to describe her map, Sarah pointed at the map and described the process of their work being a process that worked on his issues, spiraled back to her, went back to the issues, back to her, etc. Later, as she explained that they just kept going back to the issues she said, "I saw it as a spiral."

In selecting and telling the story of her clinical work with Carl, Sarah addressed her boundaries of competence concerns and described her ethical decision-making process that led to referral and resolution of her concerns. Sarah's boundary of competence concern with Carl centered around her belief that Carl needed to do work that would require intense physical expression and she knew she did not have the physical ability to facilitate this work. She was also uncomfortable using the particular techniques she was trained in, as Carl did not give her the cues she needed to be able to confidently guide his work. Additionally, she believed that Carl was avoiding his core issues and that he needed a different therapist to break through the avoidance. On reviewing her map, Sarah described her decision-making style with Carl as a "spiral." The spiral-like process involved her holding the issues she believed he needed to work through in the center of the decision-making process while she tried several intervention variations before finally referring him to a colleague.

Marti: Second Interview (Experienced Counselor)

Background

Marti is a Euro-American female in middle adulthood. She reported completing her master's degree in health science over twenty years ago. The only credential Marti holds, in addition to her state license, is that of NCC.

At the time of the interview, Marti had been a practicing professional counselor for twenty-one years, with the first seven years being full-time and the remaining 14 part-time. She has worked in community mental health centers, hospital settings, and in private practice. She has worked with adolescents and adults who range from early adulthood to the elderly. At the time of the interview, Marti was working in private practice in an urban area.

In regard to ethical decision making, Marti indicated that as a private practitioner, she has full freedom to work without limitations from an administrative structure, but acknowledged that prior to private practice work she did experience times of limited clinical freedom in ethical decision making. When asked if there would be any logistical hardship for her clients if she need to refer, her response was no. Marti selected her case for the CMT from her private practice experience.

Conceptual Mapping Task

Client selection and case overview. When asked to select a client case involving boundary of competence concerns, Marti had considerable difficulty. As she worked

to select a case where she had been outside of her experience and/or training level she became mildly agitated and simply declared, "I've just had so many [of these] cases." After a couple of false starts, she landed on a case that was very suitable for the tasks at hand and one with which she was also comfortable working.

Marti elected to work with a case involving Doris, who had presented with marital issues. Marti also assessed Doris as clinically depressed. Early on in the treatment Marti encouraged Doris to seek a medical evaluation, but this option was refused. Doris wanted Marti to help her find a resolution to her concerns that involved her desire to have a baby and her husband's lack of sexual function. Marti described Doris as a "very frustrated and very sad lady."

The husband was invited to join Doris in treatment for a couple's session. Marti described the husband as depressed and self-absorbed. She commented that the session "didn't feel very successful." At this point Marti concluded that although the presenting problem centered around Doris wanting to have a child, the real "problem was that [the husband] was impotent most of the time." She invited the husband back, but he never came again.

Marti saw Doris "maybe eight more times" before Doris just "didn't come back for awhile." During the individual sessions following the couple's session, Marti confronted Doris with her assessment. She told Doris that if she wanted to stay in the marriage, she would have to accept that her husband did not want a child. Marti believed the only alternative Doris had was to choose to leave the marriage in hopes of finding another mate who would join her in her efforts to have a child. Marti

encouraged Doris to speak with her husband about these alternatives, but Doris "decided not to do that." At this point, according to Marti, Doris "self terminated."

About six months later Doris returned to treatment with Marti for two or three sessions. According to Marti, Doris had "gotten herself on anti-depressants, because she had really gone further down." In the end Marti indicated to Doris that she didn't think she could help her further, but would locate a referral and send the information to her. Marti said, "I didn't see anything else that I could do for them or her other than refer her to a sexual dysfunction clinic." For Marti the termination was about making a "practical suggestion" in response to her realization that Doris "couldn't go any deeper with her."

Marti reported that she no longer engaged in individual supervision but did attend a peer supervision group twice a month. During phase four of the face-to face-interview Marti was asked if she staffed her work with Doris in her supervision group. Marti recalled staffing Doris on one occasion and reported the group interaction wasn't particularly useful to her.

Conceptual map description. Marti found the conceptual mapping phase to be extremely difficult. Before I asked Marti to review her Post-it® notes, which had been generated in the story-telling phase of the interview, I noticed she did not have a solid working surface and handed her the lap-board usually used in creating the conceptual map. As she reviewed the Post-it® notes Marti used the lap-board and laid the notes out in a linear fashion on the paper that had been provided for creation of the conceptual mapping. This activity created a pattern that simply followed the story step

by step from beginning to end. When she was subsequently asked to arrange Post-it® notes as a spatial representation of her process, she replied, "I must be missing something, because I don't see it any differently than it is here." I encouraged her to reflect on the arrangement of the notes for awhile and indicated that she could rearrange them if any new spatial representation pieces emerged for her. She did some minimal rearranging at that point. After she attempted to group the concepts and indicate the flow of the process, it became apparent the map was not working for her as reflected in her comments:

> I don't like it. I don't know how you're gonna figure this out. That's your problem, I guess. 'Cause I don't think I could. . . . And it doesn't allow me to do my process the way I would do my process.

Following these comments, Marti was offered an opportunity to redo her map. Marti was relieved to know she could begin again. We removed the Post-it® notes, I kept the original paper with only the circles and lines on it, and Marti began again on a fresh sheet of paper. This time the process worked better for Marti and she said, "OK, got it. I know what I'm doing now." It appeared that the problem for Marti was not just her self-confessed natural linear-thinking style, but the fact that she had laid the Post-it® notes down on the paper while reviewing them. The computer-generated map duplication shown in Figure 4 is the second map Marti created.

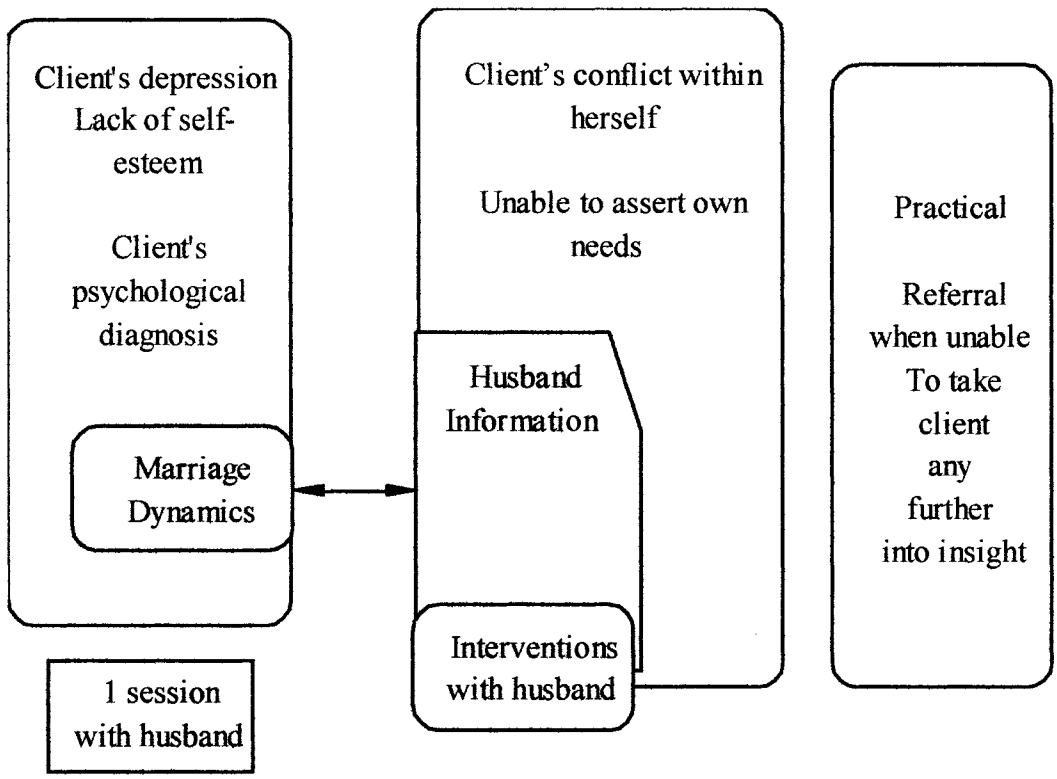


Figure 4. Conceptual map created by Marti (Experienced Counselor)

Marti's map contains three major long rectangles with two of the rectangles containing smaller content boxes. The one smaller rectangle at the bottom left, with text stating *1- session with husband*, represents a single Post-it® note that Marti did not enclose in the three major rectangles. The first major rectangle on the left labeled *Client's depression/Lack of self-esteem/Client's psychological diagnosis* contains the content box labeled *Marriage Dynamics* holding Post-it® notes describing some of the marriage dynamics. The middle major rectangle labeled *Client's conflict within herself/Unable to assert own needs* contains the minor content boxes labeled *Husband Information* and *Interventions with husband.* These minor content boxes hold Post-it® notes describing the husband's information and Marti's interventions with the husband. The rectangle on the right labeled *Practical/Referral when unable to take client any further into insight* contains the Post-it® notes describing the process of the final sessions, termination, and Marti's efforts to find a referral for Doris. The darker shading indicates content symbols labeled *Marriage Dynamics, Husband Information,* and *Interventions with Husband* were present on the map as circled clusters of concepts but not labeled by the participant. The text in these boxes is the researcher's summary of the information on the Post-it® notes in the designated boxes.

When asked to discuss the arrow indicating flow between the major rectangle on the left and the major rectangle in the middle, Marti offered the following:

> I saw the client as basically [being] depressed [and having] low self-esteem. Because of that [and having] this husband, who was self absorbed, [Doris] was unable to assert herself [and address] her own needs. That's how I connected it.

In selecting and telling the story of her clinical work with Doris, Marti addressed her boundaries of competence concerns and gave an outline sketch of her ethical decision-making process that led to referral and resolution of her concerns. Marti's boundary of competence concern with Doris involved her belief that she "couldn't go any deeper with [Doris]" and the realization that she had done all she felt capable of doing for her. Marti had difficulty in reporting her story in an ordered fashion and in creating her conceptual map. Consequently, her decision-making style did not come through in a clearly articulated manner in either her story or her map. She appears to have gone from one session to the next feeling her way through the material presented in the session and making a few suggestions along the way for things like medication, couples sessions, assertiveness, and confrontation. Marti reported that Doris sidestepped or rejected each of these interventions. Doris finally terminated the therapy and followed up with referral material via the mail.

Bob: Third Interview (Experienced Counselor)

Background

Bob is a Euro-American male in early adulthood. He reported working as a mental health provider for thirteen years. All but one of those years was full-time. Bob graduated with a master's degree in education in the late eighties. His master's degree is not in a mental health field, but he was able to take advantage of the grandfathering regulations when licensure first became available in Illinois to obtain his LPC status

based on his experience in delivering mental health services. He does not hold any credentials or certifications other than his state license.

Bob has worked in a variety of settings including both hospital and community agency. At the time of the interview, Bob was working in a community mental health agency and held a position of clinical leadership in that work setting. The case Bob selected for his CMT was from a hospital setting where he worked early in his professional career.

According to Bob, the agency in which he was working at the time of the interview is the county agency, which is charged with serving the "poorest and the sickest" of the county. Although the agency in which Bob works is technically in an urban setting, Bob reported that all of the individuals who provide services through his agency would struggle with logistical and financial realities when making referrals. Bob attributed these struggles to the fact that, although they are urban by definition, they serve communities in which mental health resources are scarce for the general population and become very sparse when considering their designated population. Bob believed that, in the agency he was serving at the time of the interview, he had "freedom to work through" treatment decisions.

Conceptual Mapping Task

Client selection and case overview. When asked to select a client for the conceptual mapping task, Bob selected his client case from a past employment

situation that was during his time as a novice counselor. He offered the following rationale for not selecting a case from his present work situation:

> We work with a pretty specific population here and I feel very comfortable. I don't feel like I've really been outside of myself with [this] population, but I can think back a few years [and] I can think of some [cases] especially as I was getting started and felt a little bit on my own at times. . . . I can think of a specific case I was working with probably about eight years ago. . . . It was my first job.

At this point we were interrupted by a staff member who needed the room we were using for a few minutes. When we reentered the room, Bob indicated he wanted to switch client cases:

> If it's okay, I'm going to switch the clients because I thought of one [where I was] probably even more over my head and I worked with her for a longer time. . . . This was actually a little bit earlier.

The client Bob named Jennifer was in her mid teens when Bob began working with her. He indicated that he "ended up working with her for about three years." Her lengthy silences (e.g., 20 to 30 minutes) during sessions, her frequent suicidal declarations over the phone followed by lengthy silence and refusal to reveal her location left Bob distraught. He described these circumstances as follows:

> That was early in my [experience and] I had a listed phone number. . . . This girl would call me on the weekends at midnight and the conversation would be, 'Bob, I'm going to kill myself' and that would be [all she would say]. But she would sit 45 minutes to an hour on the phone and not [talk]. . . . This was before caller ID and I did not know where she was at. . . . So, I got to the point where I was totally . . . trying to get her to respond after her announcement. "I don't want to live anymore," [and] "I'm going to do something to myself tonight." Sometimes there were plans and I would be totally overwhelmed, usually drenched in sweat after an hour . . . then she would hang up. I would be unable to sleep. . . . I told her we were going to have a session every day that lasted a half hour. Usually I would talk the first five minutes, but the rest of the time we would sit there in silence ... which at that time I wasn't very good at . . . and didn't understand the therapeutic process of [silence]. . . . Basically I was just

> sitting there wasting my time. . . . I went through probably years of being very lost with this client, not knowing what to do.

Bob reported regularly approaching a variety of clinical and administrative supervisors over the course of his counseling relationship with Jennifer. He described the supervision process as generally confusing, unhelpful, and at times fraught with an underlying conflict. Some of the confusion and conflict was attributed to disagreements between the various supervisors on staff at this particular agency and the lack of supervisory skill and/or insight available to him at the time.

There was no formal resolution or solid closure for Bob at the end of his work with Jennifer. After years of emotionally draining work, conducted without helpful supervisory input, she seemed to just evaporate from his caseload. Bob reported that he had thrown her last communication, which had no return address, away just months before our interview and years after his last encounter with Jennifer.

Conceptual map description. Bob seemed to move through the process of creating his conceptual map with ease. He indicated he had "never done this before," and acknowledged his sense of being a novice at this task when he said, "I'm not 100% sure if I've done this correctly." At one point in his discussion of the map, Bob asked for permission to move some of the Post-it® notes around and, as he proceeded to do so, filled in more of his story details about this case. A computer-generated duplication of Bob's map is presented in Figure 5.

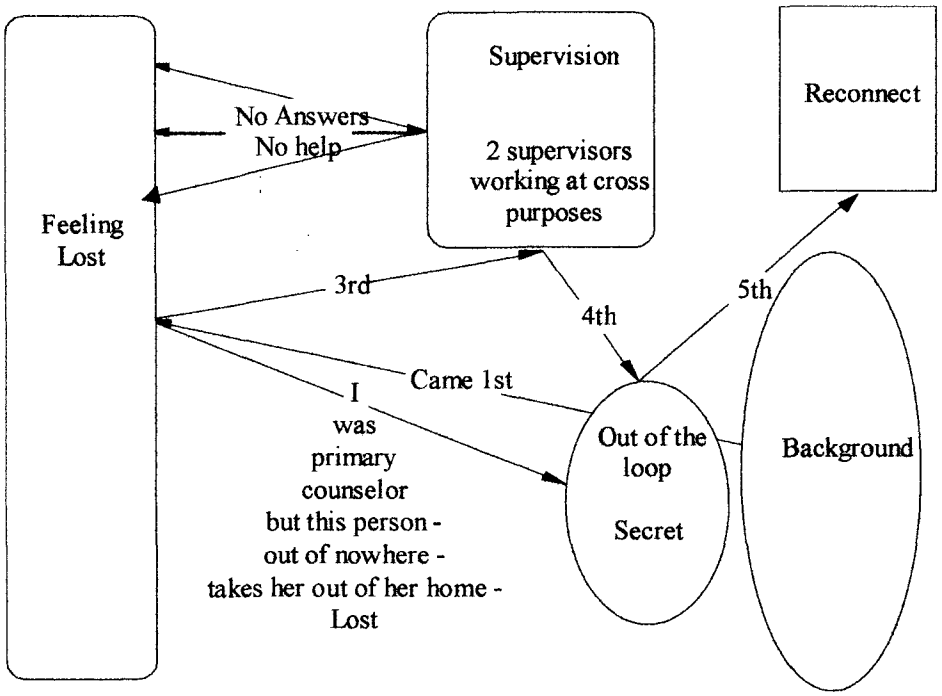


Figure 5. Conceptual map created by Bob (Experienced Counselor)

Bob's conceptual map contains five content symbols and numerous interactive flow lines. Some of the flow lines are numbered to indicate the order of the events. For Bob, this was not a linear or static process. The larger long oval on the bottom right and labeled *Background* contains information about Jennifer and her background. Bob described the long rectangle on the left labeled *Feeling Lost* as "this is . . . where I was feeling very lost and confused and not sure what I was doing."

The smaller oval to the right of center at the bottom labeled *Out of the loop/Secret* is about Jennifer moving in with one of the staff, which according to Bob "was not done with anybody's permission" and without his prior knowledge. This circumstance is clearly set out on Bob's conceptual map in the statement below and left of center and intended to label the flow line leading from the *Feeling Lost* content symbol to the *Out of the loop/Secret* content symbol. The statement reads *I was primary counselor but this person – out of nowhere – takes her out of her home – Lost.* When referencing this situation he explained that it was "almost like there was a secret."

Jennifer had somehow gotten emancipated and went to live with another mental health professional who was one of Bob's supervisors and also involved in Jennifer's mental health care. Bob expressed his confusion by externalizing his thoughts at the time by saying, "What happened, how'd she get here?"

Bob believed he was working with two supervisors who "didn't get along," as referenced in the *Supervision* square just right of center at the top of his map. This

Supervision square references all of the supervision he experienced during the years he worked with Jennifer.

Bob did not create a content symbol for the resolution of this dilemma but indicated that flow line number 5 signified the end of Jennifer's treatment with him. There was no formal resolution or closure. Jennifer just slipped away when she moved in with the other staff member. The closest Bob got to closure was during the three incidents he placed in the smaller top right square at the end of the number five arrow line labeled *Reconnect.* This symbol represents the several post-treatment chance encounters and/or client-initiated updates via mail Bob had with Jennifer after formal treatment had stopped.

Bob enumerated on the symbols and the flow at several points in his discussion of the map but particularly after he made some adjustments to the map. In discussing the numerous lines that flow in and out of the *Supervision* square he offered the following insights into the intensity of the confusing process:

> She became one of my primary clients. . . . I can remember some of the first sessions I had with her [and] just going I don't know what's going on. She's not talking. . . . What do I do here? The feedback pretty consistently being 'just keep doing what you're doing. Just sit there and let her talk or not talk, but make yourself available.' So doing that but not knowing whether that was helping in any way and then moving as our relationship developed . . . and just being there every day. I can remember sitting on the steps to the building where we were at and just feeling like I needed to bang my head on the wall because I [didn't] know what to do. Going inside [to supervision with] all those feelings and everybody seemed ambivalent.

In selecting and telling the story of his clinical work with Jennifer, Bob addressed his boundaries of competence concerns and his decision-making process as what might best be described as a jumble of system-imposed and/or system-influenced

circumstances. Bob's boundary of competence concerns with Jennifer centered around his discomfort with her silence in session and on the phone during which she threatened suicide. Bob reported that his concerns were exasperated by non-directive, and at times, conflictual supervision, dysfunctional system dynamics, and his lack of experience or exposure to silence and high-level crisis cases. When reviewing his map, Bob clearly described a process that was like a web. He reported this web as one often filled with confusion and generally overwhelming to him as a young professional. Resolution of Bob's boundaries of competence concerns with Jennifer occurred at the event level as she seemed to evaporate from his caseload. Closure of the relationship for Bob was a slow process that was not yet complete at the time or our interview. A piece of closure seemed to occur for Bob during the process of his creating and describing his conceptual map.

Matthew: Fourth Interview (Novice Counselor)

Background

Matthew is a Euro-American male in early adulthood. Matthew reported he earned his degree in Counseling Psychology from a community-counseling program. In addition to being a LCPC, he holds a Chemical Addiction and Dependency Certification (CADC) and stated that he is a "grief and loss specialist."

Matthew reported both community agency and private practice work experience. At the time of the interview, he was working in a hospice agency and in the beginning stages of developing a private practice. Matthew indicated that he has worked full-

time as a professional counselor for around three years. The agency in which Matthew worked at the time of the interview is located in an urban area in a suburban setting. Although his agency is not located in a rural area, he indicated he could foresee some situations in which clients served by his agency would encounter logistical hardships in the event of a referral. Matthew also indicated he has a "great deal of freedom" to make decisions about treatment at the agency, but in private practice he has full freedom to make such decisions. Matthew selected his case for the CMT from the hospice agency he was working in at the time of the interview.

Conceptual Mapping Task

Client selection and case overview. When asked to think of a case where, in the course of doing individual treatment, he had become concerned about being outside of his experience and/or training level, Matthew quickly indicated he had a client case in mind. Matthew described his client as "an elderly man, who had a significant medical condition." Matthew gave his client the pseudonym Franklin and began to discuss his journey with this particular individual. Matthew discussed three concerns he had in relation to his work with Franklin.

The first concern was the "tremendous age difference" between himself and his new client. Matthew framed his concern this way: "How was I, as a young energetic man, going to help an elderly man, who was probably very grounded in his ways?" Matthew referred to this as a "barrier or hurdle."

The second matter of concern was what Matthew felt was triangulation. It was Franklin's adult son who had made the call to request counseling, and it was the son who Matthew called to schedule the appointment. During this phone conversation, the son gave Matthew a lot of valuable information and let him know that he wanted counseling to "fix dad."

The third concern for Matthew was that Franklin had a serious medical condition which Matthew had a sense could impact treatment planning but had no solid clinical knowledge to inform his treatment considerations. Prior to his first meeting with Franklin, Matthew did some research because he realized that although he had some anecdotal understanding about this particular medical disorder he did not know things like medical prognosis, research, and medication options.

Matthew immediately took these concerns to his supervisor. He reported that he and the supervisor were "in constant touch with one another" during the course of the treatment. At both the beginning and the end of treatment with Franklin, Matthew received encouragement and affirmation from his supervisor. In reflecting on his first meeting with his supervisor about Franklin, Matthew said, "she gave me some confidence."

The termination with Franklin was quick and unanticipated. Matthew had set Franklin up with a volunteer to give him some socialization experience and one day the volunteer called and said Franklin had asked him not to come anymore. When Matthew called Franklin to inquire about this report, Franklin said, "I want to continue to be isolated, I pray for my day to come [to join his wife on the other side of eternity].

I've had many years of marriage and what do I do now. I am unhappy. Matthew thanks, you're a great person, but things are not changing." Matthew speculated that the "overwhelming things that were going on within Franklin" coupled with his apparent "unwillingness to change" caused things to just "fizzle out." Finally, Matthew reflected, "It was a very intense case."

Conceptual map description. Matthew approached the CMT with eagerness and appeared to enjoy the exercise. This was confirmed later in the interview when he was asked about his reaction to conceptual mapping, and he responded; "I think it's awesome. It's great. I think it's insightful and a great model for deep reflection one can do when there are feelings of incompetence or a sense of naiveté."

Matthew's map contains eight content symbols that stand alone, two smaller content symbols he placed inside one of the larger stand-alone symbols, and several flow lines that tell two significant parts of his story. The content symbols in Matthew's map are varied in shape and distinctive in the content they represent, and the flow lines tell the interactive nature of Matthews's internal process and his supervision experiences. A computer-generated duplication of Matthew's map is presented in Figure 6.

The long rectangle at the left of the map, which is connected by flow lines to the smaller square just a little above and to the left of the map's center, is titled *Presenting Information* and contains the various Post-it® notes relating to intake information Matthew gleaned in the intake process. The smaller square titled *Thoughts About where to Start* represents Matthew's diligent thinking process and stated concerns

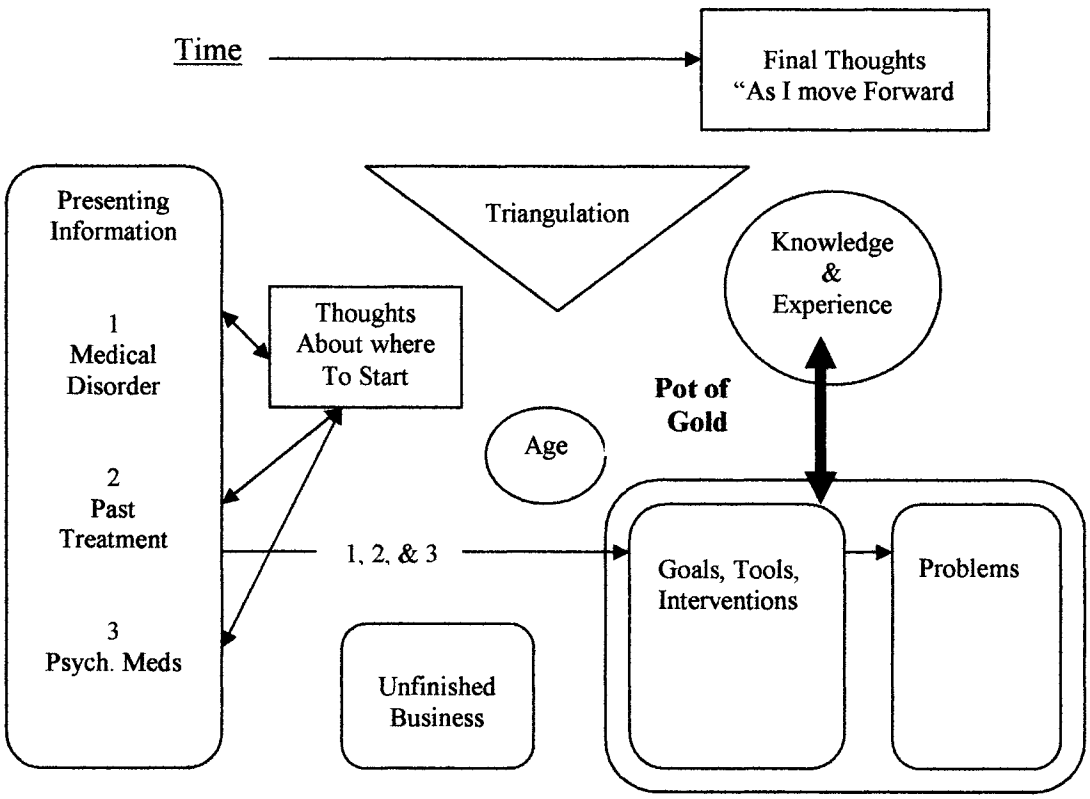


Figure 6. Conceptual map created by Matthew (Novice Counselor)

about his limits in approaching this case. The three double-arrow-point flow lines connecting the rounded rectangle labeled *Presenting Information* and the square titled *Thoughts About where to Start* demonstrate the process Matthew went through in preparing himself for his initial session with Franklin. In considering the major concerns he had in approaching treatment with Franklin, Matthew met with his supervisor, did some research on the Internet concerning Franklin's medical disorder, and did some reading about psychotropic medications common to the treatment of such disorders.

Matthew's map contains four content symbols that appear to hang in space separate from the ongoing process demonstrated by flow lines between symbols. The triangle, which is just to the right and above the center of the map, contains the Post-it® notes detailing his struggle with Franklin's son who wanted him to "fix dad." In speaking about the triangulation within the relationship, Matthew said, "It was a relationship where I felt like I was constantly in the middle." The small circle entitled *Age* represents Matthew's ruminations about the age factor, and although its placement near the center of the map may be symbolic of significance, the size may be misleading, Matthew said of this small circle "I kind of always battled with it. It was something that was pulling on me." Matthew remarked in referencing the rectangle in the upper right-hand corner titled *Final Thoughts As I Move Forward,* "As I look back, it was an awesome challenge." At this point Matthew pointed down to the rounded square at the bottom of the map titled *Unfinished Business* containing two Post-it® notes asking questions Matthew had not yet fully answered. The questions are:

"Could I have done more?" and "Was it my lack of knowledge?" The word *Time* as well as the arrow pointing to his *Final Thoughts* box seemed to be Matthew's way of communicating he will continue to ponder this case over time and use it as "something to grow on."

The two remaining content symbols in Matthew's map are central to his decision-making process. The large circle on the right and towards the top of the map titled *Knowledge and Experience* is about his supervision. Matthew spoke of this *Knowledge and Experience* circle and the large rounded square at the bottom right, which contains two internal squares labeled *Goals, Tools, Interventions* and *Problems*, as his "resource areas" and added the words *Pot of Gold* almost as an explanation point of appreciation for these resources. In reference to the *Goals, Tools, and Interventions* rounded rectangle he said, "These are the goals and tools and the areas I always went back to." He described the thick double-arrow flow line between the *Knowledge and Experience* circle and the larger rounded square as representing "the constant communication with my supervisor for knowledge and experience, problems and success as well as other stuff." The arrows labeled *1, 2, 3,* signify his constant awareness of the relationship between the information he initially received about Franklin's difficulties and his own interventions that are represented in the *Goals, Tools, Interventions* content symbol. The arrow connecting the *Goals, Tools, Intervention* and *Problems* rounded rectangles demonstrate this sense of the potential impact and limitations of his various interventions.

In selecting and telling the story of his clinical work with Franklin, Matthew addressed his boundaries of competence concerns and described his ethical decision-making process. Matthew's concerns, which led him to feel "over his head" with Franklin, included his apprehension about the age difference between himself and his client, his uneasiness about the triangulation created by the son's expectation that counseling "fix" Franklin, and his lack of knowledge around Franklin's medical condition. These three concerns combined to create a sense in Matthew that he needed to attend to his boundaries of competence in relation to this case.

His decision-making process involved identification of the problem, consultation with his supervisor, and research into Franklin's medical condition and accompanying medication options to understand the impact these things might have on the counseling process. Matthew's method of telling his story, manner in which he created his map, and his discussion of his map all illustrate a step-by-step methodical decision-making process that flows in an ordered web-like fashion. The final resolution for Matthew's concerns was Franklin's self-termination a few weeks prior to our interview. This termination left Matthew with some unfinished closure. Consistent with his decision-making style, Matthew posted two clear questions for contemplation in his *Unfinished Business* content symbol and concluded his map discussion by indicating this experience was "something to grow on."

Suzy: Fifth Interview (Novice Counselor)

Background

Suzy, a Euro-American female in early adulthood, earned her master's degree in psychology less than two years ago. At the time of the interview Suzy was an LPC and reported being only a few months short of the two years full-time experience needed to qualify for LCPC status. In addition to her state license she holds certification in psychosocial rehabilitation.

Suzy reported her only post-master's professional experience as being in the community mental health agency where she was employed at the time of the interview and quite naturally selected her case for the CMT from this setting. The agency is in an urban setting. In this setting she reported being required to consult weekly with her individual supervisor, as well as participate weekly in group supervision. She did not feel that the agency limited her freedom in clinical decision making and had experienced a great deal of freedom in making case management decisions. Because the agency where Suzy worked is a very large urban agency with multiple service offerings, referrals are made easily through an inner-agency system. She did not believe that a referral would cause any logistical hardship for any of her clients.

Conceptual Mapping Task

Client selection and case overview. When asked to select a case from her individual counseling experience in which she had become concerned about being

outside of her experience and/or training level, Suzy seemed to respond with comfort as she said, "All right" and began her story. Suzy finished her short, concise story a few minutes later, and because I was concerned that the story was not full enough to successfully complete the conceptual mapping task, I asked if there were any more details. She filled in the story effectively, but seemed unsettled.

When I reflected this unsettledness to her, she opted to begin again with a second case. Again she ended with visible discomfort. I suggested verbally walking her through the rest of the tasks involved in the interview, so she could choose between the two piles of Post-it® notes that had been generated from the differing stories. After she heard a description of the remainder of the steps involved in the exercise, she energetically and confidently said "I'll do Patrick, the first one" and quickly became involved the tasks of reviewing the notes and creating a map.

Patrick was referred to Suzy through a local sheltered living setting. Suzy shared that Patrick had a long psychiatric history with multiple hospitalizations and a variety of outpatient treatment modalities. Patrick was diagnosed as schizophrenic and was at times suicidal. Suzy shared that Patrick "had all the symptom of schizophrenia, the paranoid type, including voices telling him to kill himself," and added "I'm OK with all that because I have a lot of supervision and training around that. I'm OK with working with someone who has symptoms and who's seeing a doctor for medication." Suzy shared at various points in the interview that she really enjoyed working with the schizophrenic client and saw this as somewhat as her professional niche.

The competency concerns began when Patrick shared with Suzy that he had been sexually abused at numerous points throughout his life. Suzy was clear about her limits at that point. She said,

> When I found out about the sexual abuse, I knew that was beyond what I could do because I don't have any special training in incest, or sexual trauma. . . . When I heard [sexual abuse history], I didn't think that it was something I could do and I didn't feel comfortable working with him [around this issue].

Shortly after this point of realization, Suzy stumbled upon the resolution she needed to be comfortable continuing treatment with Patrick. She discovered that Patrick also saw James, another mental health provider, weekly just to work on sexual abuse issues. At this point, Suzy contacted James and they discussed the possibility of being a therapeutic "team" for Patrick. Within this new team approach, Suzy's work with Patrick centered on the "day-to-day symptoms associated with depression and schizophrenia" and James concentrated on the issues surrounding the sexual abuse. Suzy concluded by saying that Patrick "is doing very well right now," and went on to energetically enumerate the positive gains she had seen in his everyday function. As we were wrapping up the interview, Suzy commented that part of her comfort in continuing treatment with Patrick was that she consulted her supervisor about his progress "pretty much every week."

Conceptual map description. Suzy began creating her map with some tentativeness, but then it took off and she seemed surprised at the outcome. She finished placing the Post-it® notes and remarked, "I thought it was going to be like a rainbow but it didn't come out that way." As Suzy was describing her map, she said, "It's a journey, it really does feel like a journey." The more she looked at the map and

reviewed her journey with Patrick, the more alive her verbal and physical expression became. A computer duplication of Suzy's map is presented in Figure 7.

Suzy's map contains eight content symbols and a number of unidirectional flow lines. The decision-making process begins at the bottom of the map and seems to climb up the various content symbols to the top of the map. The rounded rectangle located in the bottom left corner of the map contains one Post-it® note giving previous mental health history information and is labeled *Began.* The next rounded rectangle, entitled *Symptoms and Therapy Content – Process of Treatment*, begins Suzy's journey with Patrick. The next step in the journey is the square content symbol labeled *Incompetent of Issue* and indicates Suzy has encountered an issue she feels incompetent to treat. The journey continues upward in the next two rounded rectangle content boxes. The first of these is labeled *Comfortable with continued treatment due to specialist*, and the second is labeled *Progress of continued treatment.* Finally, at the top of this journey, Suzy placed three Post-it® notes containing the following message labels: first, *Comfortable Journey focus on original issue;* second, *Client doing well given mix of treatment modalities;* and third, *with continued treatment, Client will be successful.* These notes are encased in the rounded rectangle labeled *Current Statement.*

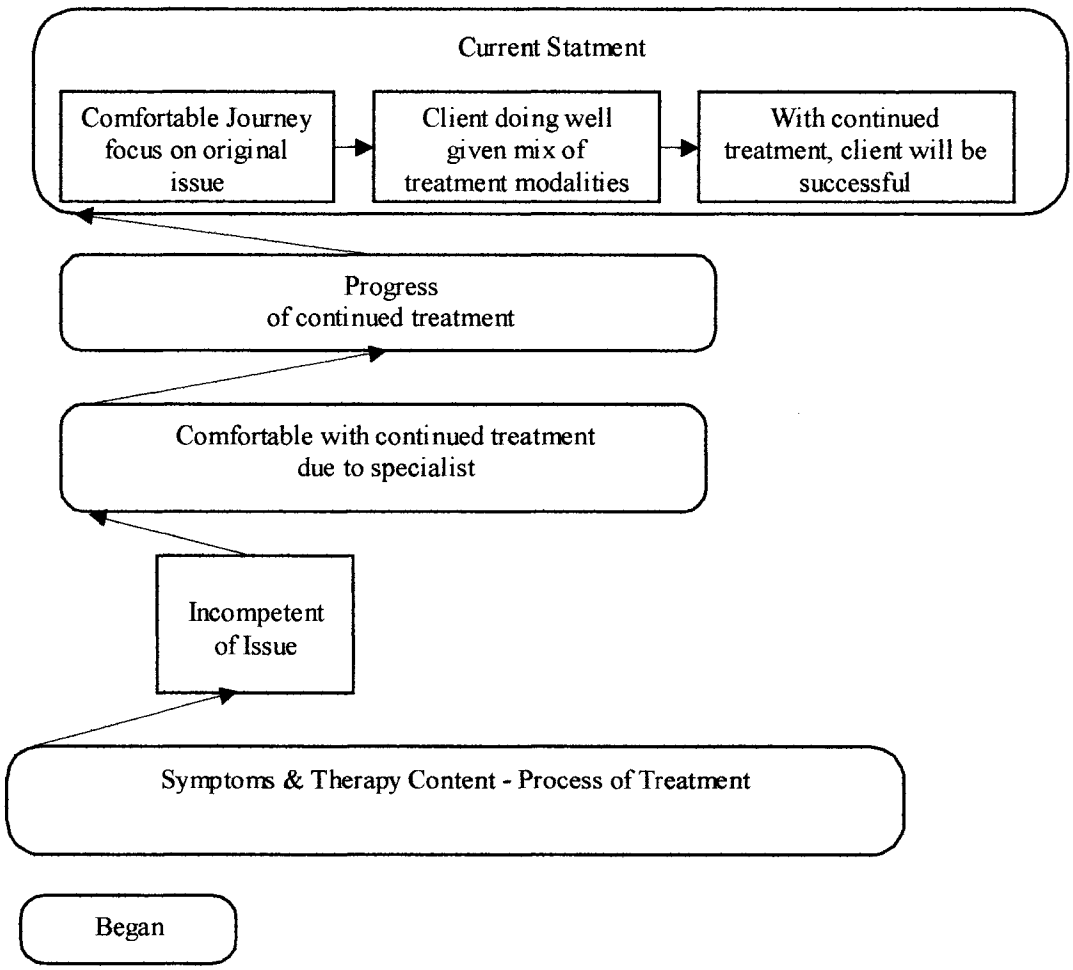


Figure 7. Conceptual map created by Suzy (Novice Counselor)

In selecting and telling the story of her clinical work with Patrick, Suzy addressed her boundaries of competence concerns and described her ethical decision-making process that leads to resolution of her concerns. Suzy's boundary of competence concern with Patrick began the moment sexual abuse issues emerged in the counseling process. At that moment Suzy reported she knew she was outside of her competence. Although Suzy stumbled upon the resolution of a team effort to treat Patrick, the process of treatment she described following this revelation was thoughtful and had the feel of a step-by-step clearly understood and articulated professional process. While reviewing her map, Suzy referred to her process of treatment interventions and/or decision making as a journey.

Daniella: Sixth Interview (Experienced Counselor)

Background

Daniella is a Latina woman in early adulthood who began her counseling career as a bachelor's-level counselor in youth services. She graduated with a master's in counseling, has practiced full-time as a licensed counselor for over five years, and is a LCPC. Daniella has specialty training and/or certification in a number of areas including play therapy and managing violent adolescent behaviors. She selected her client case for the CMT from an agency working with urban youth who required intensive counseling services.

Most of Daniella's professional experience has been in community agency or institutional settings. At the time of the interview she had just begun to see clients in a

private practice setting in addition to her full-time employment in an institutional setting. In both of these settings she was working with children and adolescents doing individual and group therapy. Daniella reported having full freedom in decision making and case management in her current work settings. Both the institution and the private practice are located in urban settings and she indicated no logistical hardship would be created with a referral process for her clients in either setting.

Conceptual Mapping Task

Client selection and case overview. When asked to select a client for the conceptual mapping task, Daniella paused to think for a few minutes and then began her story. She began by explaining her professional status at the time she encountered her selected client. She said,

> This was before I had my LCPC. I think I was even in my last year of my master's program. I wasn't even quite done with my master's program. Because I'm bilingual I had been doing therapy right out of my Bachelor's program – full therapy loads.

After she had finished telling the following story, she said "I only have three of those stories, but that's the one that came to my head."

Daniella chose to share about her work with Lucy, a teenage girl she worked with intensely over a period of three to four months. The therapy took place in Lucy's home, occurred several times a week, and at times included Lucy's parents in the sessions. When Daniella received the assignment she was given a list of Lucy's symptoms, which included "depression, oppositional behaviors, running away, smoking marijuana, and not going to school." Daniella went through the list and then

said, "so your basic teenage oppositional stuff," and indicated that these issues were very familiar to her and that she was very comfortable as she began her work with Lucy.

It was not long before Daniella began to wonder about what she was dealing with. She indicated things went well at first and that she "built a relationship with her really quickly," but then she began to see "that her moods would switch really quickly within sessions. You know, one minute she would be fine and the next minute she'd be screaming and running down the street." Daniella reported that Lucy's "acting out behaviors" would perplex her or, as she put it, take her "off guard."

In the last session Daniella had with Lucy in the home things disintegrated suddenly and violently. Daniella tells the story as follows:

> In the middle of the session she starts screaming and she starts flying off the handle. I start trying to de-escalate the situation. Mom and dad were in the house. . . . And she takes her head and smashes it into a mirror . . . and there's blood everywhere. Her parents are freaking out and at that point I was like . . . I am over my head.

At this point Daniella called her supervisor, who skillfully walked her through the procedures she needed to follow in order to transition Lucy to inpatient care. Once Lucy was in the hospital, Daniella stayed in contact with her and sought constant direction from her supervisor. Once the hospital began to share diagnostic information with Daniella, she "realized that a lot more was going on with [Lucy] than originally thought." At this point in the story Daniella said, "it was completely out of my hands at that point. . . . It was way over my head. I didn't even know what to call those

things that were going on with her." She said this as if she was one more time realizing this truth and letting it soak in a bit further.

Daniella described her termination with Lucy as a transition skillfully guided by her supervisor. Lucy was transitioned from the hospital to a long-term residential treatment center several states away. Daniella did some transitional sessions in the hospital and, at the encouragement of her supervisor, accompanied Lucy to her new residential placement. To finish up the case, Daniella conducted two last sessions with the parents. She asked her supervisor to join her in these, as "she could better explain the [diagnostic information] including some of the personality issues."

Daniella reported that she struggled with feelings of abandoning her client. She explained:

> I started to have feelings of abandonment. . . . This was the first time I'd ever had a client like this. She was so attached to me, "please don't do this to me, please don't leave me." I felt so bad because she's crying and calling me and the hospital was calling me and telling me she was asking for me. I talked to my supervisor about it and this helped me get through. . . . Considering this was my first really difficult client, it was hard for me to terminate when I had been doing such intense work with her.

Conceptual map description. Daniella's map contains eight rectangular content symbols and five flow lines that both indicate the direction of the process and the significance of supervision. As she began creating her map, Daniella was fairly tentative, but after all the clusters were circled and labeled, the flow lines drawn, and she sat back to observe her story in conceptual map form she said that "it was interesting how I [got] a sense of me as I was doing it." When Daniella finished explaining her map, she noted that the mapping process had been a good reminder

about the reality of clinical limits and had given her refreshing insights about her own process in managing those limits. A computer duplication of Daniella's map is presented in Figure 8.

Daniella began her map at the top of the page with those first initial pieces of information she had been given about Lucy and labeled the top rounded long rectangle as *Initial Evaluation.* She moved next to the shorter large rounded rectangle labeled *Symptoms/Is this my insecurity or was I not qualified for this.* The Post-it® notes in the top box are the initial pieces of diagnostic information she had and the notes in the second box are the things she began to pick up as the sessions progressed, including the rapid mood swings in session and the head-smashing incident. As Daniella moved to this second box, she said, "These are my symptoms." She followed that interesting statement with these comments which very clearly outline her inner struggle at this point in the case:

> Is this my insecurity or was I not qualified? I didn't know. So I started feeling overwhelmed and wasn't sure if I was being an insecure therapist or if I was just really overwhelmed. I didn't feel like anyone ever really talked a whole lot about [limits] in school. Like it's OK to be not qualified for a certain situation. It's OK to refer out. At this point I wasn't aware of that [option]. At this point it was like, you're the best we've got. You've got to go out there and you've got to make this work. . . . So I felt like this so far was my responsibility. At this point I'm like, am I just being insecure or am I really in over my head?

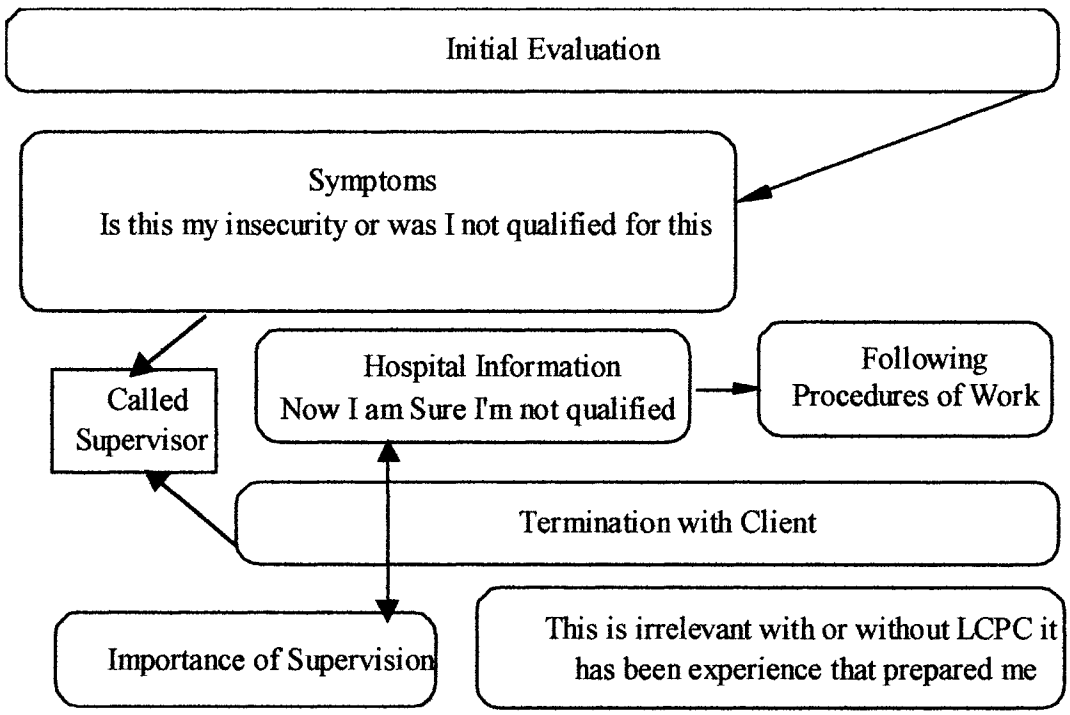


Figure 8. Conceptual map created by Daniella (Experienced Counselor)

Daniella moved next to the midsize rounded rectangle just about in the middle on the right-hand side of the map titled *Following Procedures of Work.* She said of this content symbol:

> I circled this as protocol. I didn't know to do this, this was my supervisor saying, drive to the ER, get her hospitalized and then you will have to do linkage. So this is more me following protocol.

The rounded rectangular content symbol just to the left of the procedures box and titled *Hospital Information/Now I am Sure I'm not qualified,* contains the notes about diagnostic indicators revealed through the hospitalization. Daniella pointed at this set of notes and said, "When I found this out, then I knew that I was over my head." For Daniella the *Hospital Information* content symbol and the rounded rectangle in the bottom left corner of the map titled *Importance of Supervision* are intricately linked. She described this linkage and its importance as follows:

> I put an arrow from when I'm over my head and the importance of supervision. This [box is labeled] the *Importance of Supervision* because this is where my actual supervisor came in with me and drove with me to the parents and helped me do those last two sessions. So it was really good to have that kind of support.

It should be noted here that of the five flow lines Daniella drew on her map, four of them are directly related to supervision assistance.

The long rounded rectangular content symbol second from the bottom on the left side of the map and titled *Termination with Client* contains Post-it® notes about the termination process. There are seven Post-it® notes in this content symbol. Five of these notes delineate the steps involved in the termination between Daniella and Lucy. Two of the notes are about her interactions with her supervisor that read, "supervisor helped in crises" and "staffed with supervisor."

The last content symbol entitled *This is irrelevant with or without LCPC/it has been experience that prepared me* and located in the lower right corner of the map is the only content symbol on Daniella's map that is not connected to the flow of the process. Daniella explained this content symbol as follows,

> This was before I had my [license] but I think this was irrelevant because with or without my license, it has been the experience that has helped me prepare [for the work I do] and not so much sitting down for a seven-hour exam. So that's why it's all by itself at the very end.

In selecting and telling the story of her clinical work with Lucy, Daniella addressed her boundaries of competence concerns and described the ethical decision-making process, which, in many ways, was supervisor guided. Daniella's awareness of her limitations with Lucy happened as a slow onset that burst upon her in one final session. For Daniella, the slowness to declare her limitations was complicated by her lack of clear awareness that she was allowed to have limitations. Daniella's boundary of competence concern with Lucy centered around her experience of Lucy's extreme and erratic mood swings that erupted into a full-blown violent episode during their final session. Clarity about her boundaries of competence limits with Lucy came only after the hospital diagnosis was made. Daniella said that when she heard the hospital's diagnosis, her response was, "I'm in over my head. I don't even know what that is." Daniella's ethical decision-making process might be best described as an event that demanded decisive action followed by a clearly executed termination process carefully guided by a very involved supervisor.

Sam: Seventh Interview (Experienced Counselor)

Background

Sam is a Euro-American male in early adulthood. He reported graduating with a master's degree in counseling psychology and working as a licensed counselor for nine years. Sam is both a LCPC and a NCC. Although he has engaged in a number of continuing education experiences, he did not cite any specialties or certifications beyond the NCC.

At the time of the interview, Sam was working in a community agency, but reported also having worked in several other community agencies as well as in institutional settings. Sam selected his case for the CMT task from his caseload at a community agency where he had worked as an experienced counselor several years prior to engaging in his current employment. He stated that he had full freedom to manage clinical issues in his current setting, but related that in previous settings he had experienced some systemic limits in the area of decision making. Sam reported the geographical location of his work at the time of the interview to be urban and did not believe there would be any logistical hardships should he need to refer a client to another agency or counselor.

Conceptual Mapping Task

Client selection and case overview. When asked to select a case from his individual counseling experience in which he had become concerned about being

outside of his experience and/or training level, Sam indicated that he had come to the interview with a case in mind. He seemed to have come to the meeting wanting to discuss this troublesome case. As Sam told his story it was obvious that, although the events had happened some years previously in a clinical setting several jobs and states removed away from his current work setting, the details of the case were painfully fresh in his mind.

The client Sam selected to talk about was involved in multiple services within the community mental health network in his community. Sam reported that Deb was in the "community case management program" and was "thus receiving more case work than therapy." Deb was referred to Sam for depression issues that are at least in part due to some complex grief issues. Sam reported that he did a "comprehensive intake and assessment" out of which he developed a treatment plan. In addition to her counseling with Sam, Deb continued to receive a variety of social services supports that were managed by her case worker.

When Sam received the referral, he received some information that gave him concern. Sam reports that he "was told that she was a difficult client, [who was] manipulative, did not tell the truth, was a drug abuser, and was involved in prostitution." He reported that he "didn't particularly like the idea of meeting with her." He stated,

> I felt she was being dumped on me because her therapist didn't want to deal with her anymore – that she was too dependent on the therapist and had pushed the boundaries. But I was the one she was referred to and I wasn't going to refer her to [yet] another counselor.

Several months into the counseling process, Deb revealed that she had previously been sexually involved with one of the social service providers whom she did not want to identify. Sam spoke with his supervisor about this and was told "if she's not going to give you the name, don't worry about it, just encourage her; if she would ever like to report that, she can."

Within a couple of months, Deb again referenced sexual activity with a social service worker. This time Deb identified the individual, Joe, and indicated that it was a current situation. Immediately following the session Sam notified Joe's supervisor. In a return voice mail the supervisor said, "Sam, Deb has made allegations before about different caseworkers . . . don't worry about it." At this point Sam felt that if Deb had a history of making allegations against male social services providers, "she should be switched to a female caseworker," and requested this change. He reported that he was told to relax and know that "it would be OK".

Sam continued to see Deb for therapy and she continued to talk about her sexual relationship with Joe. Sam reported that for a time he viewed these reports in the following way:

> I thought she was making it up. I thought she might be imagining this. She had a history of hallucinations, both auditory and visual. She told me she was using drugs at the time, and that she was also prostituting herself.

However, a couple of months later, Sam called Joe's supervisor again. At this point Sam reported that he was feeling conflicted because he had not spoken to his own supervisor about this matter. He speculated in hindsight that he may have been consciously or unconsciously protecting Joe. He stated,

> I was worried about getting Joe in trouble if I brought it to my own supervisor. She might have done something about it. I felt that I had already spoken with his supervisor and I didn't speak with mine and I started to become worried that I had not spoken with her [at the first mention of this situation]. This became an ethical dilemma for me.

During this second call the to Joe's supervisor, Sam had discussed these concerns and was told that the situation had been discussed in "a [interagency] supervisors meeting." Because Sam knew that his supervisor attended these meetings, he assumed that his supervisor had been in the meeting and that since she had not come to him about it, he was "not going to say any more."

Some time later Deb reported a great deal of upset because there was to be a change in her service providers and Joe was being reassigned to other cases and she would have no further contact with him. At this point Sam decided to go to his supervisor and discuss the whole situation. During that supervision session, Sam learned that his supervisor had no knowledge of this situation and was "very incensed." Sam's supervisor immediately took action to report the situation to the clinical director and the interagency individual responsible for such matters. Within a short time Sam was told that he was to terminate with Deb and that "she was going to see a female therapist." Sam was given two sessions to terminate with Deb. He reported that Deb "cried hysterically" during these sessions and said, "I didn't want you to tell them. I told you I didn't want you to. I had asked you not to say anything to your supervisor. I don't want another therapist. I thought we were working well together."

Conceptual map description. At first Sam seemed to be a bit confused about the conceptual mapping task, but after asking some questions he was able to grasp the concept and moved smoothly through the process. Sam's story generated a large number of Post-it® notes and consequently he formed piles of notes representing the various elements in his process. Each of these piles became the circled, clustered, and labeled concepts. Sam's map is made up of nine content symbols and five unidirectional flow lines. A computer duplication of Sam's map is presented in Figure 9.

The four connected content symbols on the left side of the map represent a basic overview of the case, as well as Sam's conflict about what he "should have done," and are connected to the remaining content symbols with a flow line that indicates the dynamics of the process started or flowed out of these basic elements. The top circle is labeled *Information upon Referral* but was described by Sam as "information I received about Deb throughout our time together. The next connected circle contains the information gathered in the intake and assessment sessions that lead to the treatment plan and is labeled *Assessment.* The third connected circle contains interventions Sam made with Deb and is labeled *Interventions.* The fourth connected circle is labeled *what I should have done* and represents Sam's struggle between what he did in the situation and what he was considering at the time of the interview to be what he should have done.

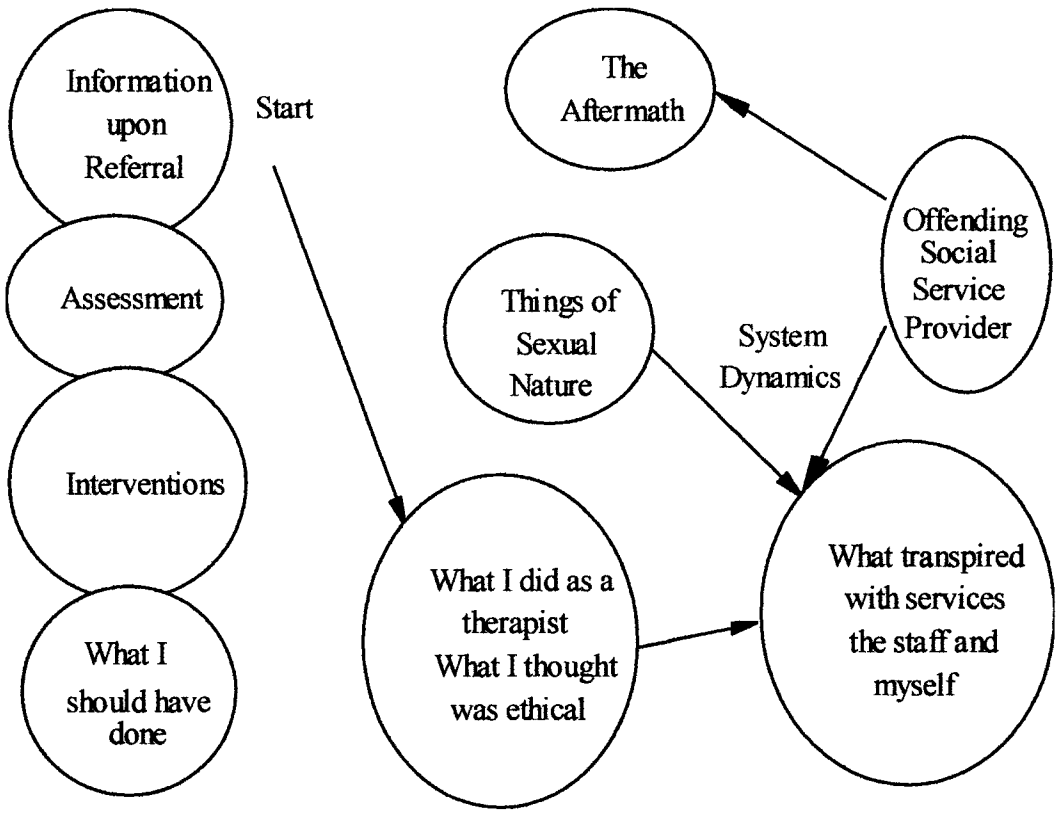


Figure 9. Conceptual map created by Sam (Experienced Counselor)

The dynamic of the decision-making process begins with the circle at the center and towards the bottom of the map labeled *What I did as a therapist. What I thought was ethical.* In describing this circle Sam said,

> My training and experiences [influenced what I] thought I was supposed to do. I was taught [that] when a client tells you not to talk about something, you don't. It's their right not to pass on information. It's a privacy between you [and them].

At this point Sam talked about how he wondered if he could have processed her reporting inappropriate interaction with other professionals better and alluded to his concern that this situation had now added to her abandonment issues.

The system dynamics are represented by the three circles that somewhat form a triangle around the words *System Dynamics* are located on towards the right-hand side of the map. The bottom right-hand content circle contains the Post-it® notes relating the details of Sam's interactions with the agency personnel including his supervisor and the clinical director, the interviews with the state that occurred after his supervisor reported, and is labeled *What transpired with services, the staff, and myself.* The circle that is labeled *Things of a Sexual Nature* contains the information that Deb gave him concerning the identified social services provider as well as some of his concerns about needing to consult the union, professional organizations, and his lawyer during the time that the agency was reacting to the information about the sexual nature of Deb's report. The final point of the system dynamic triangle is the small oval labeled *Offending Social Service Provider* containing the Post-it® notes detailing Sam's interactions with the identified social service provider's supervisor.

The final content symbol at the top and just to the right of center is labeled *The Aftermath* and is connected to the dynamic of the decision-making process with a flow line indicating that all of the dynamics ended at this point for Sam. In the end Sam was asked to leave the agency, and as he pointed to the *Aftermath* circle, Sam said, "For whatever [reason] I wanted to put this here for me. This was me at the end having a lack of confidence about getting a new job, and [trying] to get on [with my life]."

Earlier in the interview, Sam had ruminated about the aftermath of this situation and placed the corresponding Post-it® notes in *The Aftermath* content symbol. These Post-it® notes contain his ruminations about the loss of a job he loved and the legal proceedings that required his involvement. Sam's comments about his job loss were full of sorrow and grief. He said,

> You know, I had a job I really loved being an outpatient therapist. [I was] doing family, individual, and couples therapy. I felt like a real therapist. I had my own office. I wore my little Rogerian sweater and it was over.

In regard to the legal matters that transpired subsequent to the termination of this case Sam reported, "I can't tell you how many anxiety attacks I have had about [the potential legal ramifications]. I was getting on with my life and I got scared and very depressed." Sam's statement "it's affected my confidence in myself" is perhaps the statement that most sums up Sam's *The Aftermath* content symbol.

In selecting and telling the story of his clinical work with Deb, Sam addressed his boundaries of competence concerns and described his ethical decision-making process that led to a system-directed termination. Sam's boundary of competence concern with Deb seemed to have more to do with confusion about system policy than

clinical limits. Sam's first point of concern about Deb came in the referral process when he was given a glimpse of Deb as a difficult client. His concern increased when he learned that Deb had a history of making allegations against male social service personal. At this point he requested she be transferred to a female therapist but this request was refused. From this point forward, there is a general sense of confusion in Sam's process to resolve his concerns about Deb and her reports of sexual misconduct on the part of other social service providers. Sam's decision-making style in the case he selected for his CMT might be best described as confused and conflicted wandering in a system he experienced as equally confusing.

June: Eighth Interview (Experienced Counselor)

Background

June is a Euro-American female in middle adulthood. She earned her master's degree over twenty years ago and is a LCPC. In addition to her state license June holds a number of credentials including the NCC and CADC certifications and has extensive training in the area of bereavement.

At the time of the interview June was working exclusively in private practice but had spent the first half of her twenty years of professional life in agency work. All of her professional working years have been full-time. She reported she has full freedom to manage her clinical decision-making processes in private practice and added that she had experienced a great deal of flexibility in her agency work. Although June's private practice is located in an urban setting, it is not accessible by any form of public

transportation. In spite of the rather remote feeling of this urban setting, June stated that referring to another counselor would not create any logistical hardship for her clients. June selected a client she was seeing at the time of the interview case the CMT.

Conceptual Mapping Task

Client selection and case overview. When asked to select a client for the conceptual mapping task, June selected a case she was struggling with at the time of the interview. As she proceeded through the interview, it felt as if she was inadvertently using the research interview as a quasi-consultation resource. June had not previously sought supervision related to her concerns about Alice. At the end of the interview she indicated that she had found some resolution to the dilemma through the use of the conceptual mapping tool.

June selected a client whom she had seen in treatment "on and off [for a number of years]" and assigned her the pseudonym Alice. Before June began to describe her current struggle with Alice, she reviewed some of her background, including her clinical assessment that Alice "suffers from serious depression." Alice had originally presented with a complex grief reaction to the loss of a significant family member. This time Alice had returned because she was "having more problems with depression and she had been in an accident [which had resulted in some chronic pain issues]."

June reported that during one particular session Alice "slipped into the conversation that she was sexually attracted to 12-year-old boys." June immediately

felt an internal push that she believed alerted her to a boundaries of competence concern. She described her reaction saying, "I immediately felt the alarm going off. Like OH, I don't want to deal with THIS. This is not what I deal with."

June reported that this incident occurred only a few weeks prior to our face-to-face interview. During those few weeks, she had attempted to broach the topic with Alice but had met with resistance. As she ended the initial telling of her story, June said "I have been thinking about sending her to somebody who deals with these kinds of issues, but I'm not quite sure what I'm going to do yet."

June was then prompted to say a little bit more about the struggle she was experiencing. In response to this prompt, June began to verbally externalize her struggle, as demonstrated in the following statements that reveal her concerns about referral and her concerns about continued treatment:

> I know that I am thinking about keeping her [and] these are the reasons why. I know she has not sexually abused anybody. When she had mentioned it, it was like she's attracted to 12-year-old boys, but of course, she would never do anything like that because she knows how horrible that would be. So I know that she has her own struggles which are a little bit different than a sexual predator. That's the reason why I would keep on working with her. The part that makes me uncomfortable is that I have a bias against sexual predators or people thinking about sexually abusing children. That's the personal issue. And the other issue is that there might be somebody out there who could better deal with this with her. You know, the only thing is that we've worked together for quite a long time on [the depression] and I know she trusts me so I'd be concerned about that disruption because she definitely needs treatment not just for that issue but for other issues. She also was possibly sexually abused. She has lots of issues herself from childhood. She may have been sexually abused but she was definitely physically abused.

At the end of the interview, June is asked if she has any reactions to the CMT exercise. Her first response is "no." However, when asked if she got any information

about her own decision-making process as she looked at the map, June responded, "Yes, I can see that I am going to keep her. . . . I will keep her because it's my issue not hers."

Conceptual map description. June approached the conceptual mapping task with ease. She created a map containing five major and two minor content symbols and a number of flow lines. A computer duplication of her map is presented in Figure 10.

The three major content symbols beginning at the left-hand side of the map give the background facts of Alice's clinical presentation. The rounded rectangle to the far left of June's map contains Post-it® notes listing basic clinical assessment and history information. This content symbol is labeled *History,* and includes June's assessment that Alice needs treatment. June circled the Post-it® note reading *Needs Treatment* and connected it via a flow line to an identical Post-it® note she placed in the rounded rectangle labeled *Dilemmas* and found in the bottom right corner of her map. The long rounded rectangle just to the left of center in June's map contains the Post-it® notes detailing the course of treatment over the years Alice has been engaged in treatment with her and is labeled *Treatment Course.* The smaller rounded rectangle labeled *Current Issue,* which flows from the *Treatment Course* content symbol, contains the Post-it® notes detailing the general treatment concerns within the latest sequence of clinical appointments.

The two major content symbols on the right-hand side of June's map represent her identification of her boundaries of competence issue in this case and her internal process concerning this dilemma. The rounded rectangle in the upper right-hand

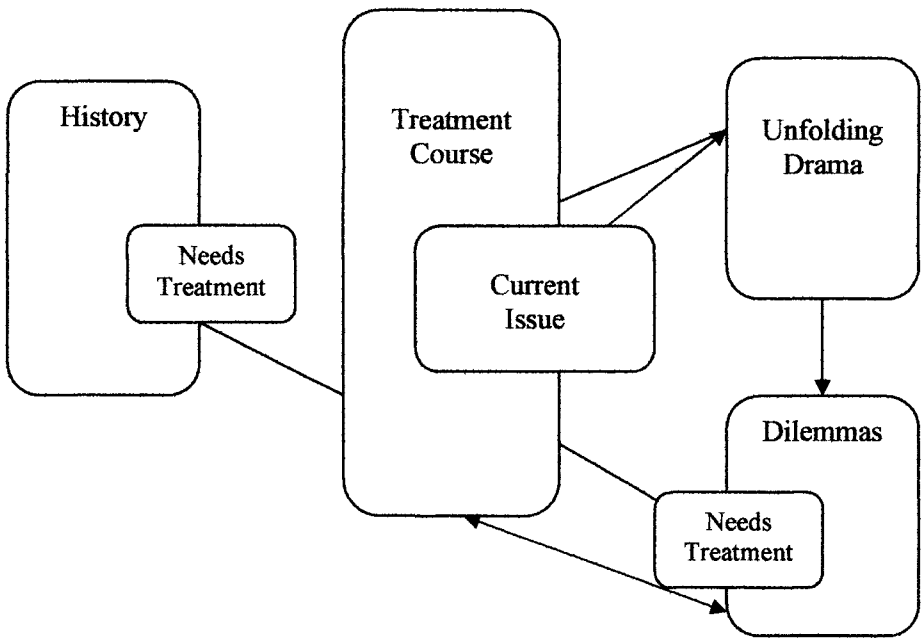


Figure 10. Conceptual map created by June (Experienced Counselor)

corner of June's map contains Post-it® notes detailing her identification of her dilemma and her initial thought to refer Alice and is labeled *Unfolding Drama*. The rounded rectangle in the lower right-hand corner of the map contains the Post-it® notes enumerating the struggle June is having as she contemplates both continued treatment and the possibility of referral. The *Needs Treatment* Post-it® note June drew a semicircle around within the *Dilemmas* content symbol highlights this aspect of her thinking.

The flow lines within June's map clearly demonstrate her process of decision making. The line connecting the two identical Post-it® notes stating *Needs Treatment* highlights her consciousness about the need for treatment regardless of her discomfort and competence concerns. The unidirectional lines that connect the *Treatment Course* and *Current Issues* content symbols with the *Unfolding Drama* demonstrate June's embedding her decision-making process in her general understanding of Alice and the overall treatment course. The double-pointed arrow that connects the *Treatment Course* and *Dilemmas* content symbols illustrate June's belief that there has to be a connection between the long-term work she has done with Alice and her decision-making process in the face of this new piece of information. The final flow line is the unidirectional line that leads from the information about Alice being attracted to 12-year-old boys and the need for a decision-making process.

In selecting and telling the story of her clinical work with Alice, June addressed her boundaries of competence concerns and worked through her ethical decision-making process that led to continued treatment as the resolution of her concerns.

June's boundary of competence concern with Alice centered around her learning of Alice's attraction to 12-year-old boys and her discomfort in working with potential perpetrators of sexual abuse. June's web-like decision-making style emerged as she reviewed her map and talked about the various interacting considerations involved in her work with Alice. Her decision to keep working with Alice seemed to grow out of weaving the various factors together until she came to the conclusion that the difficulty did not reside in the client's presentation but in her response to that presentation.

Susan: Ninth Interview (Experienced Counselor)

Background

Susan is a Euro-American female in middle adulthood. She earned her master's degree in guidance and counseling over 30 years ago, has worked as a professional counselor for 18 years, and is a LPC. Susan stated clearly that she has no plans to move to the LCPC level as she feels it is not necessary to her work as a career counselor. In addition to her state license Susan is a NCC and holds a number of certifications in career counseling.

Susan's entire professional career has been related to career counseling. She has worked in a variety of environments including community agency and higher education settings. Susan selected her case for the CMT from a previous work setting, which was during her early days as professional counselor. At the time of the interview Susan was employed in an urban setting, but due to the fact that some of her

counseling is done through distance technology, she draws clients from many areas of the country. When asked if she needed to make a referral if her clients would encounter logistical difficulties, she at first answered no. Upon further reflection, she said that for most of her clients this was true, but with the distance technology clients she had encountered some who lived in very rural areas, who found it impossible to secure transportation to access the resources she suggested.

Conceptual Mapping Task

Client selection and case overview. When asked to select a client with whom she had faced a boundaries of competence dilemma during the course of individual treatment, Susan hesitated for a moment or two and then indicated she had a case in mind. The case Susan selected was one she worked with a number of years before the interview and in a previous employment setting.

When George called for career counseling, Susan learned that he was a young adult who had been out of work for a long time and needed to get a job in his field. He stated that "he wanted to come in for some help on getting to the point [of employment in his field of training]." Susan also reported that George indicated that "he had some issues he needed to talk about first" and she "figured those issues were going to be that he had been out of work [for a long] period of time."

Although George was not forthcoming with clear and direct information, Susan quickly began to suspect that George "had some mental health issues that he may or may not have dealt with." Susan reported that at the end of the second session,

although the information was not clear, she became "very concerned." In clarifying her limits she said, "I wondered if this was going to be something way beyond what I can do. I really only do career counseling. I do not get into any kind of therapeutic counseling unless it revolves around work and the workplace."

During the third appointment George shared that he had been in "treatment for bi-polar disorder and had been on medication." Although Susan did not seek formal supervision in relationship to her work with George, she did talk with a co-worker who she reported had some "DSM IV training." Susan subsequently encouraged George to seek treatment to restart medication but he rejected this intervention. He told Susan that "it was while he was on medication that he lost his last job [and] decided that the medication caused him to lose his job. [Consequently] he decided that he was going to go off the medication."

As George unfolded his story, he shared a number of issues and, according to Susan, insisted "this will get better if I can just find a job." Susan began to try and help him see that he was spending a lot of money for the wrong service and that he needed to deal with the bi-polar disorder before he was going to be able to obtain and keep a job in his field.

At this point Susan reported she "wanted to terminate the career counseling for the time being." Her plan was to either send him back to his previous mental health professional or to provide him with a referral. According to Susan, George "didn't want to do that" because he believed and stated repeatedly that "if he just got a job, he

would be fine." Susan did continue to see George for a time and reported sharing the following rationale with George:

> I'm not going to refuse to see you because you'll find somebody else and do the same thing. But what's going to happen is you're going to be telling me after another two or three appointments that I have failed. [You will tell me] you don't have a job and it's my fault. [I'll say it again], you're wasting this money that you don't have . . . this is bigger than getting a job.

George's response to this intervention was to declare that he would continue coming and that he was not going to see a mental health counselor. Susan agreed to make another appointment but again clarified "I'll do my best, but I cannot help you deal with what you need to deal with." George came three or four more times. Susan continued to tell him she wasn't qualified to attend to the real issues and George continued to say he did not want or need to work on the bi-polar issues.

Susan shared the final termination circumstances as follows:

> Well, exactly what I predicted happened. We were strictly working on his job search process, strategy, and plan. [I was] trying to help him with the tools and that kind of thing. That's exactly what I told him I would do and nothing more. And by then he was not getting anywhere. Well, he got mad. He got very mad. He said 'you're not doing any good. I'm paying all this money.' . . . I said, 'I understand that and I agree. I would still like to refer you if you want a referral.' And he stopped coming. I don't know if he ever went to anyone to deal with the bi-polar.

Conceptual map discription. As Susan proceeded through creating her map, she seemed almost gleeful at the opportunity to capture her thoughts in this way. She chuckled and laughed as she arranged and then rearranged the Post-it® notes with a sense of an artist set free to work. In the end, Susan created a simple map that demonstrated a very interactive process. A computer duplication of Suzy's map is presented in Figure 11.

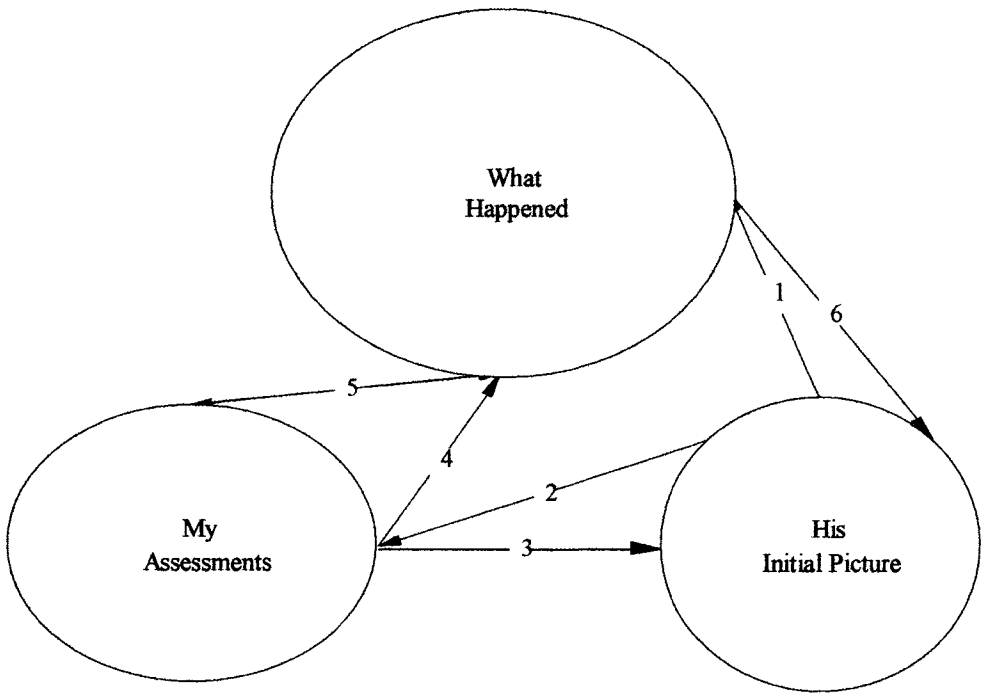


Figure 11. Conceptual map created by Susan (Experienced Counselor)

Susan's map contains three major content figures. The smaller content circle in the lower right-hand corner represents Susan's initial picture of her work with George, including a number of Post-it® notes with questions she had about the underlying dynamic of his employment history and labeled *His Initial Picture*. The smaller content circle in the lower left-hand corner containing Post-it® notes details both her assessment of George's need for mental health counseling and her understanding of her own boundaries of competence and is labeled *My Assessments*. The larger content circle in the center top of the map is labeled *What Happened* and contains the Post-it® notes describing her efforts to work with the client around her limitations and his needs.

The six flow lines depict an interactive process between the three content symbols. For Susan the process began when she approached George about her concerns described with the *His Initial Picture* Post-it® notes represented by flow line number 1. These interventions yielded more information and assessment represented by flow lines 2 and 3. These assessments led to more interventions and clarity about his needs and her limits as represented in flow lines 4 and 5. The termination, illustrated as flow line 6, comes out of the content symbol labeled *What Happened* and back to the content symbol labeled *His Initial Picture*. Flow lines 1 and 6 are in part about the back-and-forth process of working with the client to get him to accept a referral. Susan chose to use directional arrows only at one end of each flow line, but in describing the flow lines she said, "Probably they should all go back and forth [as I

look at] what actually happened." She concluded her map description by declaring it "a very interactive process."

In selecting and telling the story of her clinical work with George, Susan addressed her boundaries of competence concerns and described her ethical decision-making process. Susan's boundary of competence concern with George was clear and concise. She clearly articulated her identity as a career counselor and her belief that she was not a mental health counselor. She believed George needed mental health counseling before career counseling would be of value and built her interventions and consequent decision-making process on that foundation. When reviewing her map, Susan described a decision-making style best described as a web-like process going back and forth between the various factors and interventions that made up her counseling process with George. Susan's presentation in the interview as gracious, persistent, clear, and ordered firmness, and her ethical decision-making style, reflect these same features.

Sally: Tenth Interview (Novice Counselor)

Background

Sally is a Euro-American female who appeared to be in middle adulthood. She earned her master's degree in counseling less than one year prior to the interview. The only credential Sally holds is her LPC. However, it is noteworthy that during her less than one year of working as a professional counselor she has invested a great deal of

time and energy since earning her degree in developing her intervention skills through workshops that have presented a variety of perspectives.

Sally's professional counseling experience has been part-time in a center dedicated to women's issues, and this is naturally the setting from which she selected her case for the CMT. The center serves clients who come from a variety of urban counties and she reports there would not be a logistical hardship for her clients if she needed to make a referral.

Conceptual Mapping Task

Client selection and case overview. When asked to select a client with whom she had faced a boundaries of competence dilemma during the course of individual treatment, Sally sorted through several clients before she comfortably recalled a client situation she wanted to use for the CMT. Sally chose to tell the story of her work with a young woman she called Gail. The counseling relationship began with Gail asking for help with parenting skills and evolved into work around childhood abuse and complex relationships with Gail's parents. Sally reported two points in which she met boundaries of competence concerns in her work with Gail.

Sally reported that after months of Gail working on her stories about her mother's dysfunction and her difficult childhood, Gail "shows up with her mom." This had not been planned and Sally reported being very surprised and a bit apprehensive. As Sally spoke of her initial response to this surprise she was very animated and full of energy. She said,

> At this point I was like holy moly. [Gail] had all these terrible things to say about her mom, and how [her mom] didn't take care for her, didn't pay the bills, was depressed, wouldn't work, etc., and so she shows up with her.

Although Sally was unprepared for this meeting arrangement and had never dealt with such a situation, she agreed to the three-way meeting. Gail used the time to share some of her therapeutic insights with mom. Sally reported that she tried to act as a mediator as Gail shared "how she really felt about her life and why she wasn't motivated." As things unfolded, Sally indicated that "mom got really, really mad, started crying, and stormed out." Sally said, "Well, I'd never had that happen. So that was definitely one of those moments where I [felt over my head]." After the session, Sally processed the situation and her feelings with her supervisor. The supervisor assured her that with the role of counselor there are surprises, and then helped her process how to manage the case dynamics now that mother had been introduced into the counseling room.

Sally continued to work with Gail, who began to unpack more and more of her traumatic childhood stories. During this period of time Sally was engaged in training for an expressive technique that is often used with trauma recovery, and she suggested to Gail that they could use this technique to help her work on her memories. Gail indicated she would like to use the technique and selected a memory to work on in the next session.

After the session, Sally realized it would be good to have her supervisor's input and approval before engaging a client in this powerful exercise. When she approached her supervisor, the supervisor indicated she had no experience or training with the

techniques but did have some minimal understanding of the concepts involved. Sally reported that the supervisor "didn't have a problem at all with her using it and [indicated] she would be interested in finding out how it helped."

Sally continued to have some questions about using this particular technique with Gail and sought another opinion. She approached the individual who had supervised her during her internship experience and was met with some words of caution. She reported that the internship supervisor talked with her about some of the concerns that often accompany this type of traumatic memory work, including the client's lack of ego strength and/or personal stability, difficulty in bringing someone out of a traumatic memory into a stable present reality, and the need to understand the potential for the past being bigger than Sally had anticipated. These words of caution and instruction caused Sally to realize that she really did not have the knowledge necessary to do this exercise with her client and propelled her to do some research.

When Gail returned to session, Sally felt ready to do the planned intervention. Gail began the exercise but aborted it early in process. Sally reported feeling both disappointed and relieved when Gail chose not to follow through on the full exercise. She indicated she would still like to do the exercise with Gail but said, "She made the choice at that point and I honor that."

Conceptual map description. Sally seemed comfortable with the task of creating her map. She created a very complex map containing a number of content symbols and flow lines. A computer duplication of Sally's map is presented in Figure 12.

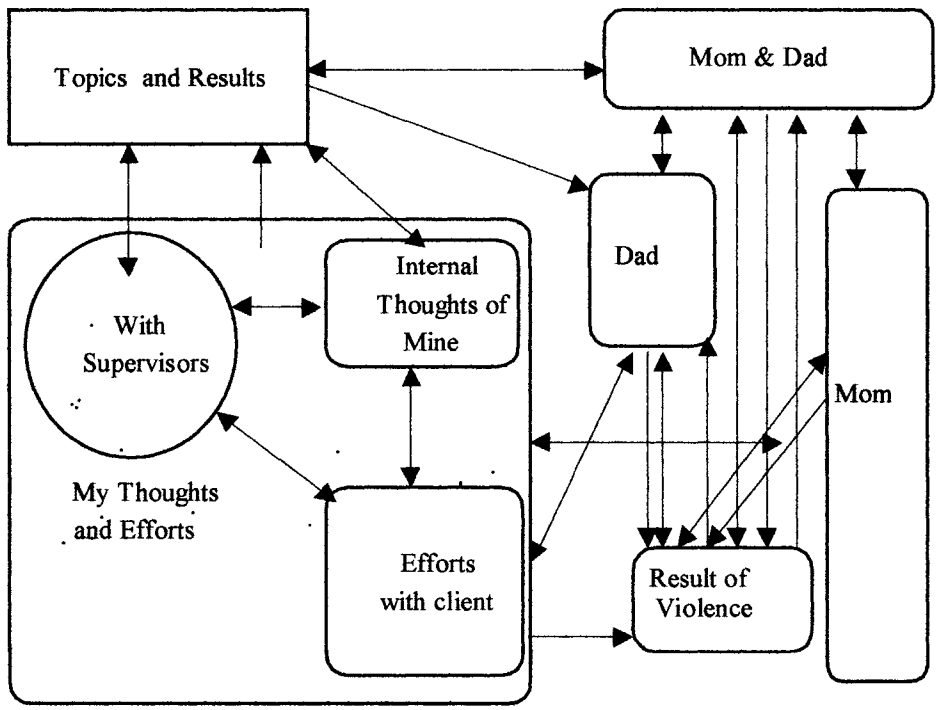


Figure 12. Conceptual map created by Sally (Novice Counselor)

The two content symbols at the top of Sally's map, which are labeled *Topics and Results* and *Mom and Dad,* serve somewhat as headers for the other content symbols in the map. The rectangle in the upper left corner of Sally's map and labeled *Topics and Results* contains the Post-it® notes that give the basic facts of the case including presenting problem, some material related to childhood dysfunction and dynamic, and Gail's goals for her future. These are the seed concepts out of which Sally developed her thoughts and efforts to help her client. The rounded rectangle at the top right of the map labeled *Mom & Dad* contains a single Post-it® note that simply states "started talking about her parents/alcoholic father and mother."

The large rounded square underneath the rectangle labeled *Topics and Results* is labeled *My Thoughts and Efforts.* Inside the *My Thoughts and Efforts* content symbol are three smaller content symbols labeled *With Supervisors, Internal Thoughts of Mine* and *Efforts with client.* The *With Supervisor* circle contains Post-it® notes detailing her consultation with both her on-site and internship supervisors. The *Internal Thoughts of Mine* content symbol contains Post-it® notes that delineate Sally's thoughts and feelings during the process, including mention of her own childhood trauma, out of which she formed empathy in relating to Gail and her stories of trauma. The rounded square labeled *Efforts with client* contains a number of Post-it® notes recounting some of her interventions with Gail.

Under the rounded rectangle labeled *Mom & Dad,* Sally formed three additional content symbols. The long rectangle on the right, labeled *Mom,* contains numerous notes detailing both the stories of mom's abuse and neglect as well as her interactions

in the therapy sessions she attended. The medium-size rounded rectangle labeled *Dad* just to the upper left of the *Mom* content symbol contains two Post-it® notes that speak of dad's abusive behavior in Gail's childhood. When she was describing this section of the map Sally suddenly said, "it is kind of . . . it's interesting how small it is . . . an interesting way to do it." These broken sentences came with a tone of new-found insight. When I reflected to Sally that it sounded like she had just seen something important about treatment, she said "yes" and let out a little gleeful laugh. She never explained what she saw but she may have learned something important. The final content symbol in this section is a small rounded rectangle at the bottom of the map labeled *Result of Violence* and references the violence being played out between Gail's children. This content symbol contains only a single Post-it® note that talks about how Gail's children were reenacting the violence of her own childhood. As she labeled this content symbol, Sally said, "[this] is kind of a result of some of the dynamics that are in [Gail's] family [of origin].

When Sally was asked if there were directional arrows or flow lines that would help complete her map, she said, "Well, I think it's all interwoven together. So if I had to draw arrows, I'd probably do arrows from every part going back and forth." Sally was invited to go ahead and draw the arrows and in the middle of the task she declared, "That's really interesting." When she was asked to explain, she said, "It's the multi-generational transmission process. How violence from [her] childhood is directly transmitted to her own children. That would probably shock her!"

There are more flow lines and arrows on Sally's original map than could be reasonably duplicated in the map presented in Figure 12 or fully explained in this synopsis. Sally did not discuss each of the flow lines, but when she was done drawing them, she was asked what she saw in the map. She responded with a long monologue:

> It looks chaotic to me. It looks like I'm over to the side - that I'm standing [to the side], holding back or something, not jumping in. You know what? That's not bad because I don't want to be in the middle of it all. My goal is not to get confused in all of this [*At this point she is pointing to the Mom and Dad section with its many crisscrossing flow lines*]. So on the positive side, I would say that I kept a healthy perspective but was still involved in all aspects [of the process]. Maybe [it is good] to keep the supervision behind the thoughts and efforts of my own. [Supervision is] a support as opposed to a direct involvement because ultimately it's my decision how I handle a situation. At first I thought it looked like a big mess but the more I think about it, the big mess is right over here [*she is again pointing to the Mom and Dad section*] and you know, that's not me.

After this monologue, Sally stopped and looked at her map and then talked a bit more about the insights she was gleaning from her map. At this point I reflected that it seemed she was doing her own self-supervision and starting to get a case conceptualization. Her response to this reflection was "YES."

In selecting and telling the story of her clinical work with Gail, Sally addressed her boundaries of competence concerns and described her decision-making process. Sally identified two boundaries of competence concerns with Gail. The first dealt with a surprise visit from Gail's mom that took her beyond her experience level and the second was related to the use of an experiential technique with which she had training but no supervised experience. One glance at Sally's map reveals the web-like pattern she described in her decision-making process with Gail. The web is complex and multifaceted, with numerous double-pointed arrows leading between the various

content symbols and in many ways is reflective of my experience with this complex, multifaceted woman who presented with remarkable energy for her new career as a professional counselor.

Jim: Eleventh Interview (Novice Counselor)

Background

Jim is an African-American male in middle adulthood. He earned his master's degree in counseling less than five years before we met for the face-to-face interview. The only professional credential Jim holds is his LPC.

Since earning his degree in counseling, Jim has worked full-time in community agency settings. Jim reported the majority of his work in these agency settings has been administrative, with only an occasional opportunity to engage in clinical counseling work. The client case he selected for the CMT came from his first post-master's work setting. At the time of the interview Jim's work setting was in an urban area. He did not believe any of his clients would encounter logistical hardship if he needed to make a referral.

Conceptual Mapping Task

Client selection and case overview. When asked to select a case from his individual counseling experience in which he had become concerned about being outside of his experience and/or training level, Jim selected a client from a previous work setting. According to Jim, this particular agency worked almost exclusively with

abused and neglected kids. He described his client as a female adolescent and gave her the pseudonym Mary.

This particular client was "a victim of sexual abuse." Jim explained that he "had quite a bit of experience in sexual abuse counseling," as he had been at this site for internship and had worked there for "some time" before being assigned to work with Mary. However, his experience was with male abuse victims and working with a female abuse victim was a new experience. He stated that he "felt pretty confident about doing [sexual abuse] counseling with little boys," but felt the gender difference presented a particularly different dynamic in the area of sexual abuse counseling. He did not feel comfortable with the situation.

Jim first met Mary in a group counseling setting where he shared responsibility with a co-therapist. When Mary became a client in individual therapy, he felt it was "something totally different." As Jim explained the difference and his concerns, he stated,

> I wasn't expecting the client to have an attraction for me. I didn't know how to deal with that and I wasn't sure what to do. I thought about just letting the supervisor know and excusing myself from her case altogether.

Jim didn't approach his supervisor at this point and decided to continue seeing Mary because he thought, "it was a phase she was going through." However, in a subsequent session Jim became unsettled when "she asked some specific questions" he didn't feel "comfortable with her asking." After the conclusion of that particular session, Jim talked to his supervisor about the possibility of "transferring the case to a female therapist." After some discussion about his feelings about Mary, his supervisor

talked with him about keeping the case, as she indicated this is something counselors encounter and she wanted Jim to learn how to deal with it. Jim reported that the supervisor gave him "pointers on what to do and say."

Jim was "still reluctant about doing therapy with [Mary]," but tried to work with the suggestions his supervisor gave him. He said, "I tried to apply them as best I could and basically some things worked and some things didn't." Jim worked with Mary for another month or so but finally decided he couldn't continue with the case. At this point in telling his story he said, "I just let my supervisor know that I didn't feel comfortable with this particular client, and the supervisor went ahead and transferred the case."

Jim met with Mary for one termination session. Mary inquired about the reason for the transfer and Jim explained that he "didn't fell comfortable with counseling her knowing that she had this attraction." Jim explained that this was not new information for Mary, as he had explained the counselor/client relationship whenever Mary would express her feelings of attraction for him. According to Jim the termination was

> just one session and then the other counselor took over. So it wasn't a joint session with three in the room with the new counselor . . . which wasn't bad because she knew [the new counselor] anyway from group sessions.

Jim concluded the telling of his story and I reflected that it sounded like he felt good about the termination. In response to this reflection, Jim expressed his sense of being "glad to be done" with this case and summed up his thoughts about the situation:

> At first I didn't really think anything about it because I didn't think the issue would come up [in the counseling setting]. And then after it did happen, I thought about it [a lot]. I thought, she is a victim of sexual abuse and nine times out of ten the abuser was a man. Now, here I am trying to do some counseling –

> working in a positive light – and it just floored me. It just floored me. It was an experience.

Conceptual map description. Jim referred to the task of creating the map as being "like a puzzle" and moved the Post-it® notes around from time to time as he proceeded through the tasks of clustering ideas and drawing flow lines. He created a rather linear map that begins at the top of the page with the *Intake/initial sessions* content symbol. He described his map as "a chain of events that happened in a specific order with one event leading to another including a solution at the end." Jim's map is made up of six major content symbols, which are connected by unidirectional flow lines, and one content symbol that stands alone at the bottom of the map. A computer duplication of Jim's map is presented in Figure 13.

The process Jim has conceptualized in his map begins with the long rounded rectangle content symbol labeled *Intake/initial session.* This content symbol contains the Post-it® notes that give some basic intake information about Mary. Jim also placed the Post-it® notes explaining his confidence and competence to work with boys around sexual abuse issues in this content symbol.

The next row of content symbols contains two shorter rounded rectangles and one free standing Post-it® note that has no label of its own. Jim described the rounded rectangle on the left labeled *Affection for Therapist* by *saying*, "all this would be all her affection for me." The stand-alone Post-it® note in this row introduces his questions about seeking supervision in order to excuse himself from the case and was labeled by the researcher on the computer duplication in Figure 13 as *S?*. One Post-it®

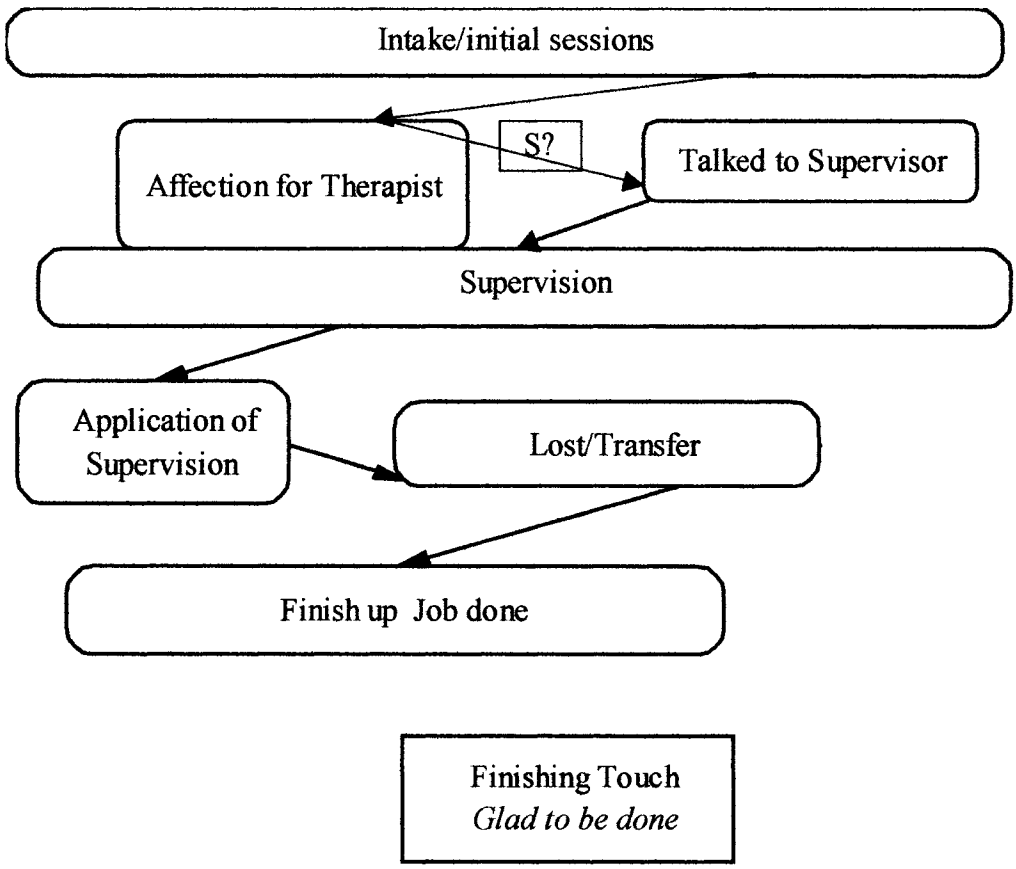


Figure 13. Conceptual map created by Jim (Novice Counselor)

note makes up the rounded content symbol labeled *Talked to Supervisor* and speaks of his action to approach his supervisor.

The next three rows of content symbols contain the process of supervision, applying supervision, and transferring Mary to another counselor. The first long rounded rectangle in this grouping of content symbols and found just above the center of the map is labeled *Supervision* and contains the Post-it® notes describe the supervision process. The next row contains two content symbols. The rounded rectangle on the left contains the Post-it® notes that describe Jim's attempts to apply his supervision and is labeled *Application of Supervision.* The long rounded rectangle on the right of this row is labeled *Lost/Transfer* about which Jim said, "This would be not knowing what to do. Lost – that will [capture] it." The final connected content symbol is labeled *Finish up Job done* and contains the Post-it® notes describing the termination process.

The final content symbol is not connected to the rest of the process and is labeled *Finishing Touch.* This square contains one Post-it® note that reads *Glad to be done.* As Jim was drawing the square around this Post-it® note, he was smiling and said, "That's the finishing touch. Finishing touch, that was it, I was done."

In selecting and telling the story of his clinical work with Mary, Jim addressed his boundaries of competence concerns and described his ethical decision-making process that led to the referral and resolution of his concerns. Jim's boundary of competence concern with Mary involved his lack of comfort in working with a female

abuse victim who was attracted to him and made physical advances. Jim's conceptual map reveals Jim's self-described linear decision-making style.

Eva: Twelfth Interview (Novice Counselor)

Background

Eva is a Euro-American female in middle adulthood who earned her degree in pastoral counseling a little less than two years prior to our meeting for the face-to-face interview. At the time of the interview Eva was a LPC but shared her plans to sit for the LCPC exam in the next several months. Although Eva did not hold any certifications in addition to her state license, her work experience, professional interests, and continuing education endeavors make it clear that she has an informal clinical specialty in grief work.

Following graduation from her pastoral-counseling program Eva began full-time employment at a community agency working with bereavement issues and had no plans for a change in employment in the foreseeable future. It is from her work at this agency that she selected her client case for the CMT. The agency is in an urban area that might be more correctly described as suburban. Eva explained that referral is a common part of her work world because the agency has a policy dictating a limited number of sessions for bereavement counseling unless there are extenuating circumstances related to the presenting issues. Eva indicated referral was not a logistical problem for her clients and added that for those who might be homebound or without transportation, her agency provides home-based counseling.

Conceptual Mapping Task

Client selection and case overview. When asked to select a case from her individual counseling experience in which she had become concerned about being outside of her experience and/or training level, Eva responded, "God, God, how many [cases should I select]." I informed her she could only choose one and she said with a tone of playful relief, "Thank you very much for that." Eva then quickly selected a client and began to tell her story.

Ed had come to the agency seeking counseling after the death of his wife. He was in his late fifties and the week he called his wife had died from breast cancer. Eva reported that during her initial intake phone conversation with Ed "he had indicated he was a 'do-er' rather than a 'be-er,' and he wanted tools to get through this bereavement." During that initial contact Ed also revealed his history of depression and expressed some concern about going back into "a black hole."

Although the agency where Eva works has a standing policy that limits bereavement counseling to six to eight sessions, Eva saw Ed for close to a year for a total of 18 sessions. Eva generally informs her clients of these limits and says, "if things don't shift [during those six to eight sessions] we will need to refer because the grief has surfaced something else." Eva spoke clearly about her belief that when new material which is beyond the grief work emerges, she is likely beyond her training and experience level.

Eva had a number of concerns that emerged throughout Ed's treatment. She had noted that Ed spent more of his time discussing his "concern about going into a

depression as opposed to [talking about] missing his wife," and the goals of the treatment all related to relief of grief symptoms. She also discovered that he had been in counseling before "many different times" and referred to him as a "therapy shopper." Eva also learned that he been on medication for depression, but because he did not like the side effects, he stopped taking them. The clinical picture was enlightened when he called her to report that he had been released from the hospital for what were likely symptoms of a panic attack. She later learned that this was more than a one-time experience.

Because of these concerns, Eva sought consistent supervision as a constant in managing her work with Ed. Not only did Eva feel like she was beyond her competence and pushing the mandate of the agency, she also began to feel that working with him was "burdensome." The sense of being burdened by Ed came as she realized he had "really come to heavily depend" on her. She talked to her supervisor often about her concerns but as they talked they repeatedly "concluded that this case was so complex . . . that we couldn't very well just say, go away."

Eva spoke with Ed on a number of occasions about the limited sessions and the possibility of a referral. She reported that "almost from the get-go he said 'well, I can really work with you and I'm not shifting. I'm not going to somebody else.'" So she began to wrap up "each session with a reminder that this was brief grief work and gave him a selection of four therapists." Each list included three men and one woman. The woman was added because Ed had said early on in treatment that he "worked

better with women than with men." Ed would respond to this information with "I really work better with you."

In the end it was Ed who made contact with a well-known specialist in the treatment of grief and cancer. When Ed shared this with Eva, she encouraged him to continue working with the other individual and in essence the termination process had begun. Ed came in one day and said, "I don't know why I'm here anymore. I'm really better." At that point Eva suggested they "start thinking about wrapping up and [that they schedule] a couple of formal termination sessions." Ed agreed, and said he'd call for an appointment after he checked his calendar. Eva has never heard from him again.

Termination with Ed without closure was difficult for Eva. Although she said "I think I did the best work I could with him," she struggles with how she could have better "encouraged him to stay with the prospect of the termination interviews." Eva reflected about the lack of formal termination, saying, "I have a sense of [this being] incomplete. It is just not complete."

Conceptual map description. When Eva was introduced to the conceptual mapping concept, she said in a playful questioning tone, "Why, what's the point of this?" As soon as Eva began to arrange her Post-it® notes and form a map, she began getting insights. The first thing she said was, "Well I can see who did all the work. It was me." This remark was followed by several verbalized insights that climaxed in "Yeah, this is sort of my own therapy session right here." Eva created a map containing a number of content symbols, flow lines, and a line of "happy squiggles all the way around." A computer duplication of Eva's map is presented in Figure 14.

Eva began discussing her map with explanations of the four content symbols that contain Post-it® notes explaining client dynamics. The oval located in the upper right-hand corner of the map is labeled *Client Control and Boundary Issues* and contains Post-it® notes about Ed's behavior and revelations that, in hindsight, felt to Eva like he was "trying to slop his boundaries all over [the process]." The circle towards the bottom of the map and just right of center is labeled *Client Resistance* and contains Post-it® notes refering to the ways in which Ed sabotaged treatment interventions. The oval in the middle and at the top of the map is labeled *Resistance Cultural* and contains Post-it® notes that refer to his being dependent on therapy but resistant to change. The oval at the top left corner of the map is labeled *Expectation of Cure* and when she came to this content symbol, Eva explained that Ed was a community client, meaning neither he nor his wife engaged in the agency's services during the dying process. She then explained how that impacts expectations of bereavement counseling:

> A lot of times community clients - because they have had no preparation for the impending death - come with a much higher expectation of a cure for grief. The first thing that we educate our clients about is that there is no cure for grief [because] this is a part of life. It's the other bookend.

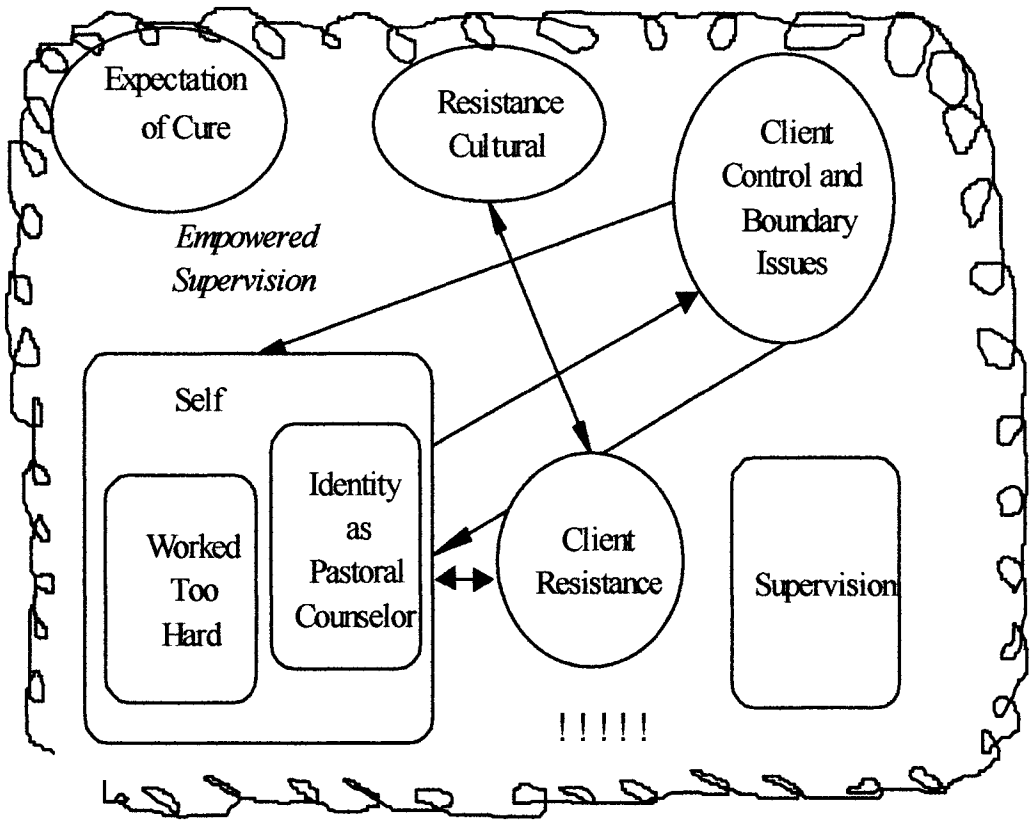


Figure 14. Conceptual map created by Eva (Novice Counselor)

When asked about the repetition of *Resistance* in the two content symbols, Eva explained that client resistance and cultural resistance are very related. And then she said as she was pointing to the *Resistance Cultural* content symbol:

> I think the resistance almost represents a cultural resistance to the grief process. We don't grieve. The first thing we do in this country is we don't get old. Secondly we don't get sick. Third and finally, we don't die, and if [someone] does die, [we] get three days off. That's mandated and then you're over it.

After this explanation about "cultural resistance to grief," Eva spent some time talking with passion about how she educates her clients about the grief process and then invites them to experience their grief within the counseling process.

Eva next turned to the rounded rectangular content symbol in the lower right hand corner of her map that is labeled *Supervision.* At this point she verbalized her need to better represent the flow of the supervision throughout the process and came upon the idea of "happy squiggles all the way around" the map. These she declared represent "the wonderful supervision I had throughout this whole episode," and then Eva explained what was "wonderful" about her supervision:

> My supervisor was affirming. This was my first big case. My supervisor kept telling me that I was doing really good work and making appropriate challenges and suggestions. But she never once said, "Oh, why don't you do it like this." There was always a sense of empowerment about my work.

After she finished drawing the "happy squiggles," she added the words *Empowered Supervision* towards the upper left-hand corner along with five exclamation points, which are located at the bottom of the map, to emphasize the empowerment.

Next Eva turned her attention to the large rounded rectangular content symbol in the lower left-hand corner of her map labeled *Self.* There are two rounded rectangles

within the content symbol labeled *Self* labeled *Worked Too Hard* and *Identity as a Pastoral Counselor,* that represent her general identity and her insights about her role and/or self perceived error in this particular case. When Eva described the content symbol labeled *Self* in her map she explained that if a person were to observe her working with clients, she or he would see the self that is the essence of her practice as a "pastoral counselor."

At this point I spoke up and indicated that I had heard her acknowledgment about working too hard and added that she also seemed to be realizing the core of who she is didn't get lost in the process. She responded, "No, not at all, but I know I worked way too hard on this one." She attributed working to hard to being a beginner, as if giving herself grace and perhaps asking for some from me and/or the profession.

In addition to the "happy squiggles" flow line, there are five additional flow lines in Eva's map. The heavy double-pointed flow line that connects the *Resistance Cultural* and the *Client Resistance* content symbols indicated the relatedness of the two types of resistance. The two unidirectional flow lines that go between the *Self* and *Client Control and Boundary Issues* content symbols demonstrate both Ed's desire to control the process and Eva's response to him during the process. The double-pointed flow line which goes between the *Self* and the *Client Resistance* content symbols reflects the interactive efforts made by Eva to work with her client's resistance.

In selecting and telling the story of her clinical work with Ed, Eva addressed her boundaries of competence concerns and described her ethical decision-making process and resolution of her concerns. Eva's boundary of competence concerns with Ed

seemed to grow out of her agency's policy regarding a limited number of sessions, which consequently had naturally limited Eva's experience with the counseling process when it extended over time. Eva also struggled with some of the dynamics Ed presented, and reported she had not had a client with these particular dynamics expressed at such a deep level. When reviewing her map, Eva described a web-like interactive decision-making style, which was surrounded by "empowering supervision." The interactive nature of Eva's decision-making style was operative with both her client and her supervisor.

Beth: Thirteenth Interview (Experienced Counselor)

Background

Beth is a Euro-American female in middle adulthood. She earned her degree in counseling nearly ten years before our face-to-face interview. Beth is a LCPC and holds no other credentials directly related to the practice of professional counseling. However, she has done extensive training around marriage and family counseling through continuing education and is committed to continuing those endeavors.

At the time of the interview Beth had devoted eight of her nine years of professional experience to full-time community agency work as a counselor, supervisor, and clinical director. At the time of the interview Beth was completing her first year of full-time work in private practice. Beth selected her client case for the CMT from her first work experience as a professional counselor, which was in a rural community agency setting.

Beth's private practice is located in an urban area according to the definition used in this study, but when asked if the need to make a referral would cause logistical hardship for her clients Beth's response told an interesting story. She said, "There aren't many services out here. When I opened my practice, I was the second full-time private practice provider in the community." Beth gave an example of a client who had a very specific presentation and explained that in reality she has no referral resource for this individual should she need one, not because of geographical logistics but because there are so few mental heath providers in her area. She often could not refer because of the nature of the issues.

Conceptual Mapping Task

Client selection and case overview. When asked to select a case from her individual counseling experience in which she had become concerned about being outside of her experience and/or training level, Beth quickly selected a client she named Anne from her novice experience days. Anne originally presented for some couple's work with her partner Doug but eventually the work evolved into individual therapy with Anne. Beth recognized all along that Anne and Doug were very disturbed but said, "I was seeing so many bizarre and impoverished people at that time, they seemed normal compared to most of them."

Because Anne's children had been placed in foster care by the Department of Child and Family Services (DCFS), and Anne was being medicated for a psychiatric disorder, there were a number social service systems involved in Anne's life. These

systems included Beth's agency, DCFS, a foster care agency, and a community agency in which Anne received psychiatric treatment. Additionally, Anne sought and received pastoral care through a religious organization that housed Beth's agency offices. Within her own agency, Beth had supervision on a somewhat regular basis. She declared the supervisor to be a "nice man" but indicated the supervision was less than helpful.

Shortly after Department of Child and Family Services (DCFS) returned Anne's children, Doug left and Anne was in crisis. They worked for a while "trying to keep [things] together" for Anne, but Beth commented that she didn't think she was "good at handling" the crisis. Anne stopped coming for therapy for a period of time.

Some time later Anne reentered treatment with Beth and things became very difficult. Beth reported that "Anne had stopped taking her medicine, was using illegal drugs, and was hanging around with some pretty tough people." Beth indicated she felt badly that she "didn't pick up on [the] schizophrenia" because Anne didn't present with what Beth knew to be classic symptoms and later she said, "I wasn't equipped." Anne once again lost custody of her children and subsequently made homicidal threats towards Beth and her caseworkers at both DCFS and the foster care agency. Because this took place in a small rural community, Anne was able to obtain Beth's home phone number and began calling Beth at home in the middle of the night. Beth reported that the threats and phone calls, which she indicated were violent in tone, caused her to believe there was no therapeutic alliance left and she terminated treatment with Anne.

One of the dilemmas Beth faced in the middle of this situation involved confidentiality. She reported that she learned quickly about the lack of consistent and/or strict confidentiality within small-town mental health systems. Anne continued to come to the building to seek pastoral care. The pastoral care provider began to pressure Beth to see Anne. At that point in her career Beth believed any discussion of this matter would be a "breach of confidentiality." However, the pressure mounted as the pastoral care provider repeatedly asked, "Why wouldn't we help Anne? What was wrong with us?" Beth stated that, in the end, "we told him that she had threatened to kill me and then he backed off." As Beth told this story, many years after the events had taken place, she was still uneasy about the resolution. She believes she was placed in a compromising situation in which she was over her head.

As Beth summarized her story she said,

> Looking back on it, I wasn't equipped. I didn't see it coming. I just didn't see the signs. I didn't recognize it. I didn't know how to deal with someone threatening me. And I think that's where my early skills of reliance on easier, shorter theories had its limits when you're dealing with the violent, chronically mentally ill. . . . I didn't know a lot in a lot of ways. I don't think I was equipped for the severity of what I was doing, and, to defend myself, no one was. We were blindsided.

Conceptual map description. Beth moved easily through the task of creating a conceptual map. She created a map with a variety of content symbols and a couple of flow lines. During her discussion of the map she creatively added a brick wall to communicate what she believed to be her self-protective defenses. A computer duplication of Beth's map is presented in Figure 15.

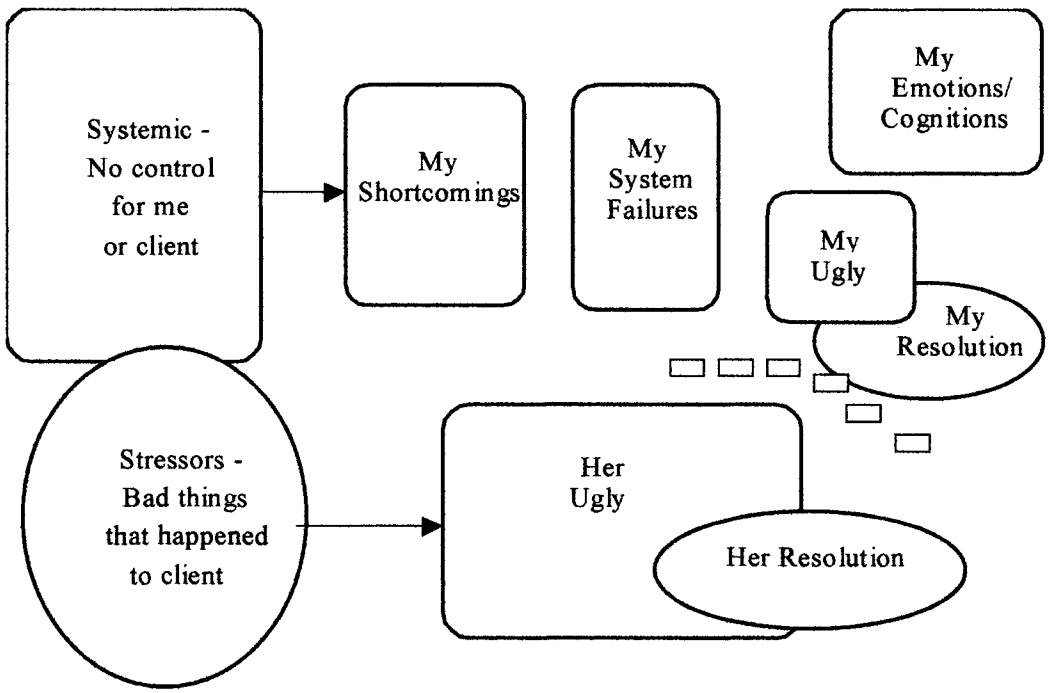


Figure 15. Conceptual map created by Beth (Experienced Counselor)

Beth began discussion of her map with the two content symbols on the left-hand side of the map that flow into the process as she saw it for her client and herself. The large rounded rectangle at the top left of the map is labeled *Systemic - No control for me or client* and represents the systemic factors related to DCFS actions involving child custody as well as other dynamics resulting from the various providers interventions in Anne's life situation. Beth reflected that these were the facts about matters that were out of her control and out of her client's control. The oval content symbol located at the bottom left of the map and labeled *Stressors - Bad things that happened to client* represents the stressors that happened to Anne. As Beth was describing this content symbol, she reflected, "This is the bad. This is the ugly. [It's] not all bad. Like DCFS returning the kids [early on] wasn't a bad thing." It was as she noted this last fact that she added the word *Stressors* above the *Bad thing that happened to client.* After she did that, I reflected to her that it seemed she really cared about Anne. Her response was powerful. She said, "She grabbed my heart. She's bright. She's beautiful. The kids were wonderful."

Beth then moved to the two symbols that flow from the content oval labeled *Stressors – Bad things that happened to client.* Of the rounded rectangle labeled *Her Ugly,* Beth simply said, "This is her ugly." The Post-it® notes in this content symbol are mostly about what Beth termed the "ugly" things that happened to Anne due to her mental disorder and DCFS interventions that "pushed her over the edge. The long oval at the bottom right of the map is labeled *Her Resolution* and contains three Post-it®

notes telling the story of Anne moving out of the area, having kids placed in foster care, and refusing further treatment.

The discussion then moved to the content symbols at the top of the map flowing out of the content symbol labeled *Systemic – No control for me or client.* Beth worked her way from left to right, beginning with the rounded square content symbol labeled *My Shortcomings.* This content symbol contains the Post-it® notes about her sense of being a novice counselor, her naiveté about DCFS and community mental health dynamics, how training did not equip her, and her theoretical orientation was inadequate for the severity of Anne's situation.

Beth continued her map discussion by explaining the content symbol that is a rounded rectangle labeled *My System Failures.* She explained that this content symbol references the failures, shortcomings and/or difficulties within the systems around her. The Post-it® notes in the *My System Failures* content symbol include items such as having a "nice," but geographically distant, supervisor who was not particularly helpful; dealing with the "pastor pushing hard for information"; the inevitable dual-role relationships between mental health providers and clients within small towns; the lack of power given to law enforcement personnel to deal with a threat before it is acted upon; and the callous attitudes of other caseworkers dealing with Anne and her children.

The next content symbol Beth explained is the small, rounded square labeled *My Ugly* that overlaps the long oval content symbol labeled *My Resolution.* When Beth described the *My Ugly* content symbol, she said "and this is my ugly . . . for lack of a

better term." The two Post-it® notes in this content symbol speak to her sense of having failed Anne and her kids and her acknowledgement that she didn't go into the counseling field to have her life threatened. Although Beth never directly spoke to the *My Resolution* content symbol in the map discussion, she made a number of clear statements about how this experience changed her professional life. The two Post-it® notes in the *My Resolution* content symbol are about how she has come to see her position as a professional counselor as including a "client advocate" piece and how this case was the turning point in her "understanding the seriousness of this business."

Beth then moved to the rounded square content symbol in the upper right-hand circle labeled *My Emotions/Cognitions*. As Beth described this content symbol she said, "My emotions: This is what I felt internally. I feel like I failed her. I still do. I would handle all this much differently today." The three Post-it® notes in this content symbol reflect some very powerful messages in succinct words such as: "Scared; Really painful for me; lots of guilt; traumatic."

When I asked Beth to indicate the flow of the process in some symbolic way, she began by drawing two unidirectional arrows. She drew an arrow between the large oval content symbol located at the lower left of the map labeled *Stressors – Bad things that happened to client* and the large rounded rectangle labeled *Her Ugly*, and commented, "In very many ways this section led to her ugly." She then drew an arrow between the large rounded rectangle labeled *Systemic - No control for me or client* to the smaller rounded rectangle labeled *My Shortcomings*, and made some interesting

comments as she began to draw little squares between the content symbols labeled *Her Ugly* and the two content symbols *My Ugly* and *My System Failures*:

> This section led to my ugly and I allowed my feelings to build a wall between us. I allowed my feelings to build a wall between us. Today I wouldn't. I needed a brick wall then. I had maybe a little picket fence at the time. I needed a bigger wall with these people (said as she pointed to the *My System Failures* content symbol). I think the other thing I didn't realize was the power of position. You have a lot of power in your position [as a professional counselor] and you have to know how to use it wisely.

As we wrapped up the interview, I asked Beth if she had any reactions to the conceptual mapping exercise. Her response was strong and full:

> Yeah! I see it as losing my virginity (laughs). [I see] how much this has impacted me. I'm no longer afraid to be a bitch or to be seen as a bitch to the system. I don't care. What's important is my client and I will be a bitch for them. I will do what needs to [be done]. I will advocate, especially with people who are powerless in the culture like people who are poor and mentally ill. They especially need really aggressive advocacy. I didn't understand about advocacy. I do now.

In selecting and telling the story of her clinical work with Anne, Beth addressed her boundaries of competence concerns and described her ethical decision-making process that was laden with systemic frustrations. Beth described her boundary of competence concerns with Anne as overwhelming, because she was not knowledgeable enough about the intricacies of Anne's mental disorder, the system dynamics of DCFS, or the interplay of agencies in rural communities. As Beth told the story of her work with Anne, it was a story of disorder and fragmented chaos, but after she created her map and began to talk her way through it, the ordered, clear clinician she has become in the intervening years emerged. As Beth described her conceptual

map, she described a web-like process full of her own emotional engagement in the clinical and decision-making processes.

Bill: Fourteenth Interview (Novice Counselor)

Background

Bill is a Euro-American male in middle adulthood who earned his master's degree in counseling less than five years ago and has less than two years of part-time clinical experience. In addition to his graduate degree in counseling Bill holds other graduate degrees in church ministry and is an ordained minister. Bill is a LPC and does not hold any other credentials as a professional mental health counselor.

All of Bill's professional counseling experience since earning his master's in counseling has been part-time and church-based and it is out of this setting that he selected his client case for the CMT. Bill reported that he has "both freedom and limits" when making clinical decisions. The church out of which Bill does his professional counseling is located in an urban area. Bill does not believe any logistical hardship would be created for his clients when he makes a referral.

Conceptual Mapping Task

Client selection and case overview. When asked to select a case from his individual counseling experience in which he had become concerned about being outside of his experience and/or training level, Bill easily selected a client he was seeing at the time of the interview and gave him the pseudonym Ray. Bill explained

that Ray was a member of his congregation who had been unemployed for nearly a year and engaged in the counseling relationship because he needed to talk with someone. It was Ray's wife who had indicated Bill as the potential counselor and as the counseling relationship unfolded, the wife became a helpful informant. Bill consulted with his supervisor early on in the process with Ray and was encouraged to engage Ray in setting goals for treatment. He reported meeting with his supervisor only twice a month and indicated that her input was helpful but not particularly critical.

After Bill had seen Ray for a number of sessions, he had a surprise visit from Ray's wife. Ray's wife was very upset about the changes she had seen in Ray. She reported that Ray had some behaviors that were full of rage. The time Bill spent with Ray's wife was helpful in his developing a diagnostic picture and potential treatment interventions. Bill recounted his internal process at this point:

> I began to think to myself, what I have here is a man certainly in mid-life passage. He hates what he's doing and probably wants a change. [There is] no question [any longer about] about a [diagnosis of] depression. He probably needs to be seen by a psychiatrist. I'm thinking they probably could even use some family therapy, as the [intergenerational] boundaries are really inappropriate. The wife is a strong person but in need of supportive therapy at this point.

As Bill revealed his thinking about Ray and his wife, he identified his boundaries of competence concern, saying,

> I'm looking at all of this and I think to myself: This is beyond me. I cannot do this. This is beyond me. I just don't have the supportive resources here and there are many, many things I do in the role of pastor which [limit my counseling practice. I cannot be seeing clients who are having a serious [mental health] problem. Also, I get a little bit frightened in the area of rage-full behavior.

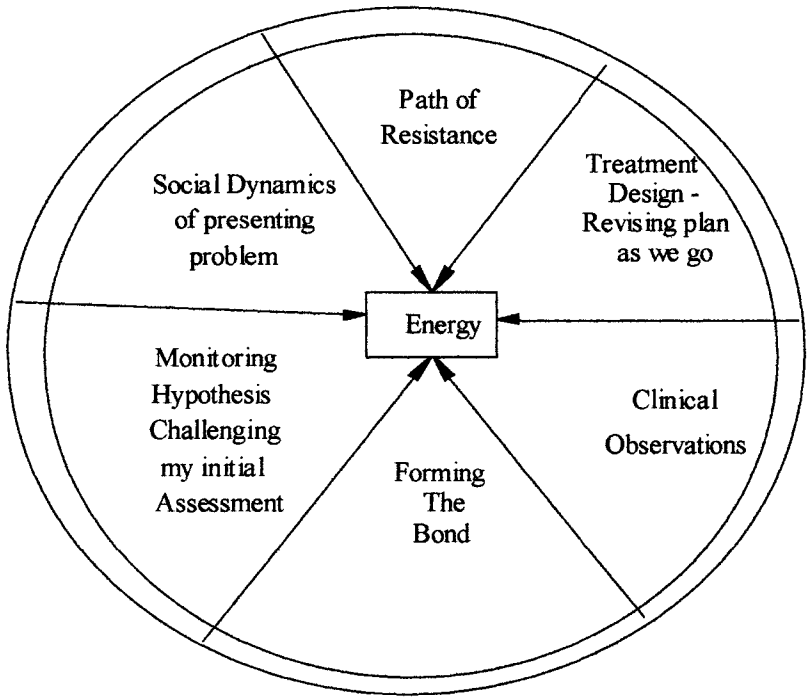
Subsequent to gaining these insights, Bill decided on a plan to discern what, if any, parts of the treatment he could continue to do. Bill had already referred Ray for a psychiatric consultation and invited the couple to take a pen-and-paper relationship assessment inventory. At this point in the interview Bill speculates that the relationship assessment will assist him in knowing if he can help them work out their marital conflicts. Bill concluded his story with his ruminations about the multiple roles he was beginning to have in this family and further consideration about his competence level:

> I will refer her to another therapist. I need to get her out of here because I have this long [counseling relationship] with him and I'm not sure it would be best for me to be seeing both of them individually. I think she needs to see somebody else individually. I think I could at least do the beginning [relationship] assessment, but it's likely that there could be some really deep-seated issues here for both of them. I would have to make another assessment [if this is the case]. If they're really hurting and I'm not making any progress, I would probably refer him to another person [and/or refer them for marriage counseling]. I could see him on a supportive basis. . . . If I don't see any progress, I'm going to send them off to somebody else. That's just about where I am with them right now.

Conceptual map description. Bill approached the creating of his conceptual map with energy. He described his map as representing progressively deepening layers that should be seen not as a "flat piece of paper" but rather more accurately as a bowl. A computer duplication of Bill's map is presented in Figure 16.

The discussion of Bill's map began with him giving this overview.

> I see it as a picture. It is a circle which starts at the outer edge. The opening salvos [are at the outer edge] and as trust increases and the relationship develops, I see [the process] getting more and more to the issues the person really wants to talk about. [Counseling] usually starts with some external problem, so I've tried to put the cards on the outer ring that are the beginning point of defining [the external problem].



1. Outer Ring - Beginning point/ Bonding with client
2. Increasing Feeling of Safety & Trust by client-issues become more focused & Vulnerable

Figure 16. Conceptual map created by Bill (Novice Counselor)

He labeled the outer ring the *Beginning point/Bonding with client.*

Next Bill made a movement with his hands towards the center of the circle and indicated that after the initial material has been presented, the process moves to the second or inner ring. He labeled the inner ring *Increasing Feeling of Safety & Trust by client – issues become more focused & vulnerable* and indicated this as being the place where transference takes place. He said that the six unidirectional arrows, which divide the circle into content areas, indicate the therapeutic movement from presenting problem to the client's revealing the underlying dimension of the presenting issue. Bill stated clearly that he believes "there needs to be increasing trust, comfort, and safety" for the movement to take place.

At this point in the interview, Bill began to describe the six content areas within his circles. He began with the area labeled *Path of Resistance* and said, "the longer I'm with him, the more I'm feeling this resistance in him." Next he moved to the area labeled *Social dynamics or presenting problem* and shared that this contains information he gathered when the wife came in to share her perceptions. Bill next pointed to the area labeled *Monitoring Hypothesis Challenging my initial Assessment* and indicated these were the Post-it® notes that referenced the content of the early sessions and his "reflections and monitoring of [my] initial hypothesis."

Bill then jumped to the opposite side of the map and spoke about the area labeled *Treatment Design - Revising plan as we go* and said,

> This is not so much information gathering but thinking about what I can do to help these people. I consult my supervisor. We get more trust, more of the [underlying] issue [is revealed], and the process gets closer to the core.

Next Bill moved to the area labeled *Clinical Observations* and gave himself a little lecture about the importance of "really hearing and [working] to understand" the client. He concluded this monologue with the observation that "there is sort of a mixture here of movement and technique." I interrupted him and said I wanted to verbally record the fact that he accompanied his statement about movement and technique with distinctive hand gestures. He had swooped his hands over the whole map, moving them in a circular motion ending in the center when he said "movement," and with the word "technique" he moved his hands back to the outer edge of the map. His response to that was interesting:

> I think the movement of the session is that you're getting closer and closer to what the [real] issue is but as you deal with issues and they go away, you find new issues. New issues keep emerging. There are layers here. . . . There are themes which replay themselves as you move into the center. [You find] new layers. It's not smooth. It is two steps forward and one step backward and that's OK.

When Bill had finished describing the content areas and movement of his layered-bowl map, I inquired about the blank space he had left in the middle of the map. He said, "To me, what's in the middle is a lot of energy." At this point I invited Bill to label this energy and he selected a Post-it® note, which was a different color from the other Post-it® notes, and labeled the center as *Energy*. He indicated that the color selection had to do with his desire for the center to be a distinct expression of the joy he finds in the energy emerging for him in the center of the counseling process.

In selecting and telling the story of his clinical work with Ray, Bill addressed his boundaries of competence concerns and described his ethical decision-making process that was still unfolding as we ended the interview. Bill's boundary of competence

concerns with Ray seemed to be about two differing and yet connected issues. The first issue was that of his clinical knowledge and experience with serious depression and/or other mental health disorders. The second was connected to his setting. Bill was concerned about the lack of mental health resources immediately available to him within the church setting, and with the potential dual roles of counselor and pastor. He believed that this role overlap would become too complicated if he engaged in long-term in-depth counseling with Ray and/or Ray's wife for either individual or couples therapy. Bill reported that he was beginning to feel the stress of holding too many roles with Ray and his family. Ray described his map, his approach to counseling, and his decision-making style as a bowl, which as it moved toward the center, was made up of ever-deepening circles of understanding about client dynamics and the counseling process.

CHAPTER 5

FINDINGS: ANALYSIS OF DATA

Grounded theory data analysis requires the constant comparison of data in order to discover and form concepts that are then organized into categories (Babchuk, 1997; Backman & Kyngäs (1999); Dick, 2000; Glaser, 2002; Glaser, & Strauss, 1967; Pandit, 1996; Strauss & Corbin, 1994). Dick defines this constant comparison as "initially comparing data set to data set; later comparing data set to theory" (Coding/Constant Comparison, p. 1). Comparison of the data sets yields theoretical properties of the categories (Glaser & Strauss). These categories and their properties, sometimes called sub-categories, sub-sub-categories, and sub-sub-sub-categories, are then studied to understand their connections to one another. It is out of these connections that theory is formed. The final step is a comparison of the theory with the literature.

Analysis of the data followed constant comparative method steps outlined by Glaser and Strauss (1967). Each interview was transcribed and analyzed in conjunction with participant conceptual maps. The first step was to create categories based on the concepts and incidents reported by participants. As successive participant transcripts and conceptual maps were analyzed, the researcher compared incidents for inclusion in the existing categories and/or new categories and created sub, sub-sub, and sub-sub-sub categories as they emerged within existing categories. The second

step involved integrating the categories and their sub-categories through the constant comparison of data. The third step involved the delimiting of the theory, or in this case, the research-based emergent model. The fourth and final step in generating theory is presenting the theory or model. The emergence of a research-based model addresses the first research question proposed for this study. The model is presented in Chapter 6.

Data analysis is presented in two major sections. The first section is the response to the second and fourth research questions, which asked for a comparison of novice and experienced counselor decision-making patterns. The second section presents the six categories and sub, sub-sub, and sub-sub-sub-categories that emerged during the data analysis. Five decision-making categories and one conceptual mapping research tool category emerged from the data. Participants described differing situations and courses of action that resulted in resolution of their dilemmas. The five categories and their sub, sub-sub, and sub-sub-sub-categories are presented in this chapter. In Chapter 6 the decision-making categories are presented as the five areas of consideration, which formed the research-based model. The model is referred to as the emergent model, and is presented in conceptual map and discussion form.

SIMILARITIES AND DIFFERENCES

BETWEEN NOVICE AND EXPERIENCED COUNSELORS

Two of the four research questions for this study asked for an analysis of the data that would provide a comparison of novice and experienced counselor. The first

question, which is question 2, requested a comparison between novice and experienced counselor ethical decision-making processes. The second question, which is question 3, asked for a comparison of how novice and experienced counselors implement their decisions regarding referral or continued treatment. However, the data collected for this study cannot answer these questions.

At the beginning of phase two of the face-to-face interviews, the interviewer read the following request to each participant:

> I would like you to think of one client case where, in the course of doing individual treatment, you became aware that you had just heard or had been hearing a client concern that was outside of your experience and/or training level.

Participants were not asked to select a case from any particular setting or time in their professional practice experience. As a result, experienced counselors were free to select cases from their early practice experience. It is clear that at least four of the seven participants from the experienced group selected client cases from their early days as practicing professionals. Although three of these individuals indicated some items they would have done differently, these give only a fragmented picture of how they would have handled the decision-making process as experienced counselors. The data therefore reflect eleven stories of ethical decision making from novice counselor experiences. As only three experienced counselors selected client cases representing their experienced counselor status, it is not possible to address the similarities and differences between novice and experienced counselors from the data collected for this study.

CATEGORIES AND THEIR SUB-CATEGORIES

Analysis of data generated from the 14 interviews which were conducted for this study generated five decision-making categories and one research category related to the conceptual mapping research tool. The five decision-making process categories are: therapeutic relationship, supervision dynamics, system dynamics, outcome, and aftermath/post-outcome reflection. The participant reaction to the research tool category is the one research-related category and will be presented following discussion of the decision-making process categories.

All categories were generated from both transcribed interview data and participant conceptual maps illustrating their decision-making process. The terms "decision-making process" and "ethical decision-making process," as they are used throughout this discussion of the data, refer to the entire process of decision making. Participants started the process at the point they became aware of their boundaries of competence concern and ended with aftermath/post-outcome reflection. In each category, sub-category, sub-sub-category, and sub-sub-sub-category pertinent individual participant data is presented in the order in which participants were interviewed. Participant map data directly illustrating or supporting a given category, sub-category, sub-sub-category, or sub-sub-sub-category is discussed at the end of each relevant section.

According to Backman and Kyngäs (1999), in their article on the grounded theory approach to qualitative research, "there is no single style for reporting the findings of qualitative research" (p. 151). The discussion of the data for this study will

be presented as categories, sub-categories, sub-sub-categories, and sub-sub-sub-categories. According to Glaser and Strauss (1967) the design of grounded, constant, comparative analysis is to generate categories that will then be used in "generating theory" (p 21). In this study, the "generated theory" is the ethical decision-making model that emerged during analysis of the data. Throughout the course of Chapters 5 and 6, the model generated from this study will be referred to as the "emergent model." Discussion of the model, which formed out of the decision-making process categories and connections between these categories, will be presented here in Chapter 6.

A conceptual diagram will accompany each of the five decision-making categories. The shading in each of the diagrams represents a distinction between the major and minor concepts that have been gathered into categories, sub-categories, sub-sub-categories, and sub-sub-sub-categories. Non-shaded areas of the category diagrams represent the categories. The lighter shaded areas represent sub-categories and the darker shaded areas, found in the therapeutic relationship, outcome, and aftermath/post-outcome reflection categories, represent sub-sub-categories. Sub-sub-sub-categories are not presented in the diagrams. The diagram for the therapeutic relationship category, which is identified as the core category, is marked out with distinct and thick boundary lines. In grounded theory research the core category is identified as the category which emerged with high frequency, and is linked to all or many of the other categories (Dick, 2002). Each of the five decision-making category

diagrams corresponds to a section of the conceptual map presented in Chapter 6 (Figure 22), which illustrates the emergent model.

Therapeutic Relationship Category

The therapeutic relationship is a clinical relationship between counselor and client. In this study the therapeutic relationships are defined as the interactive bond between clients and counselors, which has "specific tasks and goals to accomplish to help clients resolve problems" (Hill & O'Brian, p. 35). As the 14 participants in this study told their stories of ethical decision-making and boundaries of competence concerns, they did not speak of the therapeutic relationship as a sterile clinical commodity. The stories told by these participants were told from a professional perspective infused with a sense of personal care. The therapeutic relationship category presents data about the relationship between participants and their selected clients. These data involve dynamics, which both counselor and client brought to each therapeutic relationship, and the manner in which each played out his or her role within the therapeutic and ethical decision-making processes.

The therapeutic relationship category is the core category in this study. Data for this category are found throughout the reported ethical decision-making processes of all 14 participants. The data in this category are linked to system dynamics, supervision dynamics, outcome, and aftermath/post-outcome reflection categories. According to Dick (2002), this frequency of occurrence in the data and linkage to other categories is what defines core categories in grounded-theory research.

There are two sub-categories within this category. The first is the client dynamics sub-category, which has two sub-sub-categories. The second is the counselor dynamics sub-category, which has three sub-sub-categories. Figure 17 illustrates the sub and sub-sub category breakdown within this category. Two of the sub-sub-categories within the counselor dynamics sub-category have sub-sub-sub-categories. These are the only sub-sub-sub-categories and they are not represented on the diagram in Figure 17. The flow lines going between the two client dynamics and counselor dynamics sub-categories represent interactive dimensions of the therapeutic relationship. These interactive dimensions are discussed within the counselor awareness of and response to competence concern(s) sub-sub-category.

Client Dynamics Sub-Category

As participants related their selected client cases, each included some information about her or his general understanding of client life context including background and stated presenting concerns. A number of participants also spoke of their perceptions about the client's approach to the counseling process. The client dynamics sub-category contains two sub-sub-categories, which are (a) client background and (b) client presentation and approach to the therapeutic process.

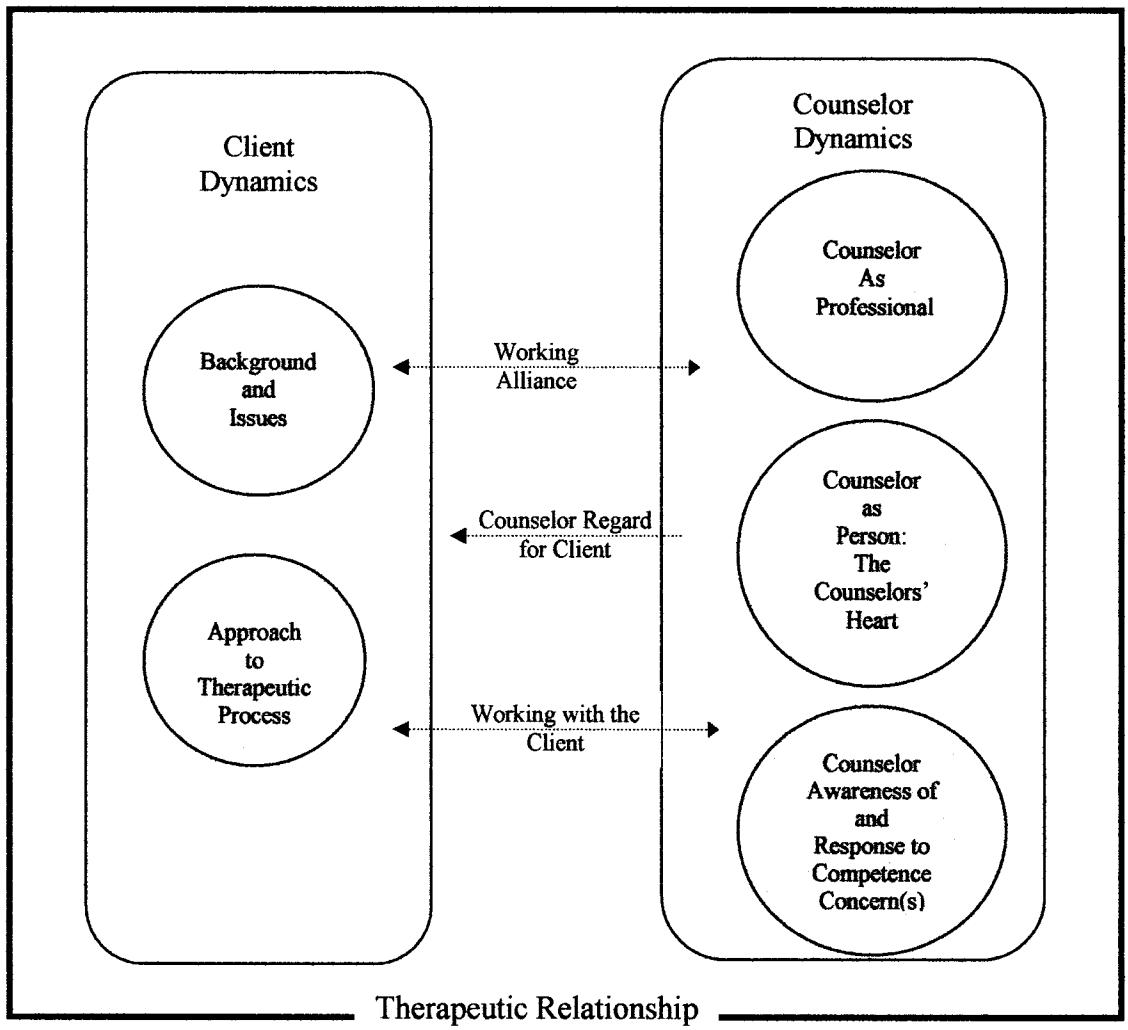


Figure 17. Therapeutic Relationship Category Diagram

Client Background Sub-Sub-Category

Although participants were instructed to begin their client story at the point they became aware of boundaries of competence concern, every participant began her or his story with background data on the client. It could be argued that it is common practice for all mental health professionals to present some background information when explaining client cases and therefore this is not a significant finding. However, what was striking in the analysis of these data was how participants consistently pointed out the background circumstances surrounding client difficulties and/or the life circumstances in which the client was managing their concerns as they explained the process that led to resolution of their particular concerns. The participants seemed to report client background and context as an intricate piece of the entire decision-making process.

A second notable aspect of the participants' presentation of background data is the manner or tone in which they delivered the information. As participants presented background information about their clients, there was a sense of "humanness" in their descriptions. Generally, there was a distinct graciousness to the manner in which participants explained their client's circumstances and struggles. They did not recite the generally accepted clinical data in a sterile fashion. There was life and story evident as participants introduced their clients as people who had a context out of which their stories and concerns emerged. For whatever reason, it was important to these participant counselors to put flesh and bones to the names and clinical data they were about to share.

The participants wove these background and context pieces throughout their stories of ethical decision making. This intricate weaving of client context and ethical decision making created a significant amount of data. Only a few examples from some of the participants have been extracted here in order to demonstrate how participants intertwined context considerations into the decision-making process.

As Sarah described Carl and his circumstances there was a sense of joy about having worked with this individual. She pointed out some touching pieces of his life that occurred during the time he saw her for treatment. An example of this was her reporting that Carl had lost his mother during this time. Although this piece was not a central part of the concern Sarah had in working with Carl, it seemed to influence her decision-making timing.

Sam spoke respectfully about Deb and her circumstances. Although Deb had been involved in drug use, reported times of prostituting herself, and sometimes related information which caused Sam to question the authenticity of her stories, Sam consistently presented Deb as an individual he saw as worthy of respect and careful case management. Early in their relationship he had wanted her transferred from his caseload, but as they developed an increasingly significant therapeutic relationship, he expressed his concern about the appropriateness of referring her. Consequently, he was very concerned about Deb's welfare when the agency management ordered him to terminate with her. Their therapeutic relationship had become part of the context of Deb's life that influenced Sam's perspective that termination was not in the client's best interest.

June was very careful to explain her client's life history, the circumstances that caused Alice to return to treatment a second time, and their long-standing therapeutic relationship. In working through the CMT June spent time musing over these pieces of information before she reached her conclusion to continue treatment with Alice. The following statements are excerpts from June's transcript as she was describing her map and deciding how to resolve her dilemma:

> Initially, when she came to me, she had lost a child and she had had a serious grief reaction. She was physically abused and possibly sexually abused. It was obvious she needed treatment then and does now. I've been seeing her on and off for eight years. She's 32 now. She has trust issues but over the years we have formed a therapeutic alliance. She came back to me six months ago. She was suffering from extreme depression and had been in an accident. She has some chronic physical issues. . . . I'm not sure yet what I'm going to do. I'm also thinking about keeping her because of the therapeutic alliance we have.

June had an acute understanding of Alice, her life history, and context that she used to inform her decision-making process during the face-to-face interview.

Beth expressed her understanding about Anne's history and circumstances with great energy. She believed she was unprepared to work with the particular biologically-based mental illness Anne presented and felt her education had failed to empower her to fulfill the role of advocate she has come to believe would have been helpful to Anne. The ethical decision-making process came to an abrupt dead end when Anne threatened Beth's life. Despite this dramatic and difficult end to the relationship, Beth talked about her work with Anne with great respect for Anne's dignity, concern for her welfare, and upset with the greater mental health system she believed contributed to Anne's difficulties. The following excerpts from Beth's transcript demonstrate her weaving of background, decision making, and compassion:

> Anne had had her two children placed under foster care for a period of time. She was living with Doug. When they first called, I didn't know they were involved with DCFS. Then DCFS decided to return the children. . . . Anne and I eventually got into some individual work around some parenting issues.
>
> Things were going really well for her and then Doug walked out the door, which was devastating for her. . . . I did not know she was being treated for a psychiatric disorder, all the time it was really being well controlled by medication. . . . And then, when he left, we worked for a while trying to keep it together.
>
> She stopped coming [to counseling] for a period of time. . . . Right before they took the kids away she'd returned to therapy and I could see that she was in really bad shape. I still didn't pick up what we were dealing with [this particular psychiatric disorder], but then she was really good at holding it together for an hour. . . . She ended up being kicked out of her home and then DCFS got quite involved. They put her up in a hotel in a drug-infested neighborhood and eventually they found her high. So they took the kids away again. At which point she threatened to kill her case workers and me. After that we decided that [I could not see her anymore].

Later in the interview Beth remarked:

> Anne was white and bright. . . . She was bright, she was beautiful, and the kids were wonderful. . . . Bad things that happened to her and [there was] just so little in terms of resources for her.

Beth's reflection on her work with Anne is peppered with her understanding of Anne's life context. Beth's continual and compassionate explanations of Anne's background and life context are the characteristics of this client background sub-sub-category. In analyzing Beth's transcript, it was apparent that Beth's presentation of her ethical dilemma and her understanding of Anne's life context were intricately intertwined.

Participant maps highlighted background information and client concerns in the client background sub-sub-category more consistently than in any other category, sub-category or sub-sub category data. Every map includes at least one content symbol

designated to background material and/or material enumerating client life context considerations for participant ethical decision making. Six participants created two content symbols applying to this sub-sub-category and one created three. Because of the volume of data contained in participant conceptual maps related to client background and concerns, Table 31 was created to give an overview of this data. The first column in Table 31 lists the conceptual map figure number that corresponds with each participant map figure. The second column identifies participant and client by name. Column three lists the content symbol labels participants used to highlight background.

There are two characteristics common to the client background sub-sub-category. These characteristics are the inclusion of client background and/or context in the ethical decision-making process and the compassionate or humane manner in which participants presented the contextual information. All participants included background and context information in their ethical decision-making process. Several participants, notably Sarah, Sam, June, and Beth, presented background and/or context information with a sense of human care and concern. Table 31 demonstrates that client background and context data played a significant part in the participants' presentation of their ethical decision-making process.

Table 31

Client Background Content Symbols

Figure #	Participant/Client Identity	Client Background Content Symbols
3	Sarah/Carl	*Start (1)* *Back to Issues (0)*
4	Marti/Doris	*Client's depression/Lack of self-esteem* *Client's conflict within herself*
5	Bob/Jennifer	*Background*
6	Matthew/Franklin	*Presenting Information*
7	Suzy/Patrick	*Began* *Symptoms & Therapy Content = Process of Treatment*
8	Daniella/Lucy	*Initial Evaluation* *Symptoms*
9	Sam/Deb	*Information upon Referral* *Assessment*
10	June/Alice	*History*
11	Susan/George	*His Initial Picture*
12	Sally/Gail	*Mom & Dad* *Dad* *Mom*
13	Jim/Mary	*Intake/initial sessions*
14	Eva/Ed	*Expectation of Cure*
15	Beth/Anne	*Stressors – Bad things that happened to client* *Her Ugly*
16	Bill/Ray	*Social dynamics of presenting problem* *Clinical Observations* *Monitoring Hypothesis Challenging my initial Assessment*

Client Presentation and Approach to the Therapeutic Process Sub-Sub-Category

It is, of course, natural to assume the client has a role in the therapeutic process and outcome. It was not anticipated that client presentation and approach to the therapeutic process would be a factor in the ethical decision-making process. However, Sarah, Bob, Sam, Susan, Sally, Jim, Eva, and Beth indicated presentation and/or client approach to the process as part of their boundaries of competence concern and thus a factor in the decision-making process. Matthew, Suzy, Daniella, and June indicated that, although client presentation and/or approach to treatment were not a part of their boundaries of competence concern, it was as an aspect in the process of decision making.

Sarah uses expressive techniques as her modality of treatment and felt that in the use of these techniques she was not getting cues from Carl that informed her about his progress. Carl's lack of verbal expression during Sarah's interventions using expressive techniques caused her to question the value of her work with Carl. His lack of verbal expression eventually led her to believe Carl might be better served by a counselor who did expressive modalities designed to get at issues primarily through physical expression and consequently not as dependent on verbal expression. Carl's non-verbal approach to expressive treatment was a key factor in Sarah's decision to suggest a referral.

Bob's initial boundaries of competence concern was Jennifer's silence in sessions and her between-session suicidal phone calls. Although, in the end, these concerns seemed to get superseded by negative systemic dynamics, they were the

concerns that initially precipitated Bob's boundaries of competence awareness. It was the mix of these concerns and the lack of clear clinical guidance that led to Bob's sense of "feeling lost." Jennifer's in-session presentation of silence and between-session phone calls were chaotic. Both of these factors were intricately related to the process of therapy and fundamental precipitants in alerting Bob to attend to his boundaries of competence.

Sam's decision-making process was filled with confusion. Sam indicated that Deb was an active participant in the clinical process. It was Deb's reports of sexually inappropriate behavior on the part of a secondary social service provider she named Joe that bewildered and disturbed Sam. In the course of the interview Sam vacillated between reporting his belief in her report and his questions about the accuracy of her statements. Sam explained his mixed sense of being influenced by a number of factors, including data he received at the point of her being referred to him, input from Joe's supervisor, and Deb's own reported behavior.

Sam explained that when he received the referral to work with Deb, he was given the following profile of her history and clinical presentation:

> When she was referred, I was told that she was a difficult client, she was very manipulative, did not tell the truth, she was a drug abuser – main drug of choice was cocaine, that she was involved with prostitution.

As he told his story, he moved from Deb's reporting about a non-agency provider who she would not name to an agency provider she did name.

After Deb identified the offending social service provider as Joe, Sam approached Joe's supervisor. Sam was informed by Joe's supervisor that it was Deb's

nature to "make allegations" and she was not to be believed. Later in the interview, as he was talking about Deb's continued reports of sexual activity with Joe, Sam said,

> I thought she was making it up. I thought she might be imagining this. She had a history of hallucinations, both auditory and visual. She told me she was using drugs at the time and that she was also prostituting herself.

Sam's final experience with Deb's approach to their relationship came when he told her he had been mandated by the agency management to terminate their therapeutic relationship. He reported her saying:

> I told you I didn't want you to tell them. I had asked you not to say anything you know to your supervisor. I don't want another therapist. I thought we were working well together.

Sam's report of Deb's presentation in treatment is very mixed. At points in the interview he appeared to believe Deb's reports of sexual activity with her social service providers and at points he didn't. At the end of the interview Sam said, "I really never knew what to believe." Sam's confusion about Deb's reports seem to be the core of his ethical dilemma and intricate to his boundaries of competence concerns. In spite of his ambivalence about the accuracy of her reports concerning Joe, Sam did indicate throughout the interview that Deb approached treatment as an active participant who did some significant pieces of clinical work. Deb's approach to treatment as an active participant who was interested in change seemed to be a factor in Sam's decision-making process all along the way.

The core of Susan's boundaries of competence concern was the reality that George "had some mental health issues that he may or may not have dealt with." Susan had limited her counseling practice to career counseling and knew she was

beyond her boundaries of competence concerning George's "mental health issues." However, George's approach to career counseling was complete resistance to seeking help for his mental health issues. Susan reported her treatment interventions as significantly revolving around George's resistant approach to needed mental health counseling.

Sally reported two situations that surfaced boundaries of competence concerns. Only one of these concerns involved data relevant to client presentation and/or approach to treatment. Sally's client, Gail, had surprised Sally by bringing her mother in for a session. When she saw Gail sitting with her mother in the waiting room Sally reported her internal response as:

> I was like holy moly! She had all these terrible things to say about her mom. "She didn't take care of her. She didn't pay the bills. She was depressed. She was on medicine. She wouldn't take a job, etc., etc." And then she shows up with her.

This situation left Sally with no freedom to ponder or consult. It required her to make a decision in the moment. In this case, client presentation and approach to one particular session was the boundaries of competence concern that required Sally to engage in an immediate ethical decision-making process.

Jim reported Mary's approach to treatment as heavily laced with her attraction to him. Jim reported the attraction led to some inappropriate behaviors in sessions. Jim's entire boundaries of competence concern was linked to Mary's attraction to him.

Ed initially presented for counseling with Eva for grief counseling related to the recent death of his wife. Eva reported that during the initial intake "Ed indicated he was a 'do-er' rather than a 'be-er,' and he wanted tools to get through his

bereavement. He [also reported] a history of depression and expressed a fear that he would go into a black hole." Eva reported experiencing Ed during their early sessions as having "a flat affect" and being more "concerned about going into a depression than missing his wife."

Eva's agency generally limits counseling to six or eight sessions. According to Eva the agency believed that after six or eight sessions clients either have worked through their grief issues or moved into material beyond the mission of the agency. As Eva related approaching the session limit with Ed she said,

> Typically we tell clients at the start of work, "this is six to eight sessions and then if things don't shift, we need to refer because the grief has surfaced something else." Almost from the get-go Ed said, "well, I can really work with you and I'm not shifting. I'm not going to somebody else." So we spent a lot of time talking about that.

Interestingly, she reported that she learned further into the counseling that he was a "therapy shopper" who had investigated "many different types of treatments."

Eva explained how Ed's presentation of "I'm not shifting" impacted her decision-making process:

> I'd talk about this in supervision. My supervisor and I concluded this case was so complex we couldn't very well just say "go away." It was out of the usual realm of what we treat here. So I kept emphasizing the brief nature and the client kept responding "I really work better with you." [In the end] I saw him for close to a year. We'd worked our way up to 18 sessions.

Eva indicated that Ed's resistance to her suggestions for referral, which were expressed regularly in his insistence that he could only work with her, were core to his approach to counseling with her and key to her boundaries of competence concerns.

Beth presented Anne as a person whom she cared about. It was Anne's diagnosis, and her involvement in multiple mental health agency systems, which Beth indicated were her boundaries of competence issues with Anne. Beth did not feel prepared to handle either the severity of Anne's mental illness or the dynamics of the mental health service agencies involved in Ann's case. Anne's mental illness and the actions of her other providers seemed to merge together, causing Anne to present in treatment with a good deal of chaos. Beth was able to see through the chaos to the "beautiful" and "bright" woman who presented herself for treatment. Beth's descriptor of Anne as "beautiful" referred more to the essence of Anne's internal self than to her physical appearance. Although Beth presented in the interview as generally caring person, she seemed to have been particularly taken by Anne.

It would be impossible to separate Beth's description of Anne as a person, how she presented for treatment, and her circumstances from Beth's story about her process of treatment, case outcome and aftermath/post-outcome reflection in regard to this case. Beth's boundaries of competence struggles with Anne's diagnosis and the impact of multiple-agency involvement were halted when Anne threatened her life. This presentation of Anne as potential murderer was the final factor in deciding the outcome of this case, but as Beth told her story, it seemed to be a minor part of how she viewed her boundaries of competence struggles with Anne. Anne's presentation as an client who was an impoverished, disturbed, beautiful, and bright woman seemed to be factors that had a greater impact on Beth and her reported ethical decision-making process than did Anne's presentation as the potential murderer.

The boundaries of competence concerns for Matthew with Franklin were their age differential and Franklin's medical diagnosis. Matthew described Franklin's overall approach to treatment as resistance including a lack of interest in change. It was Franklin who terminated treatment and ended Matthew's boundaries of competence struggles related to the case. Franklin's termination statements demonstrate his resistance to therapy and change. He said to Matthew,

> I want to continue to be isolated. I want to continue to be a victim of my [circumstances] and I pray for my day to come. I've had 50 years of marriage and what do I do now. I am unhappy. Matthew thanks. You're a great person, but things are not changing.

Matthew did not link boundaries of competence concerns and client presentation, but he did link client presentation to course of treatment, outcome, and aftermath/post-outcome reflection.

Suzy did not link boundaries of competence issues and client approach to treatment but she did link Patrick's approach to treatment with outcome. Patrick had initially presented with schizophrenic and life management concerns. Boundaries of competence issues surfaced when Patrick revealed that he was a victim of child sexual abuse. Although Suzy felt very competent to deal with the schizophrenic and life management issues, she did not believe she had adequate knowledge about sexual abuse to treat Patrick in this area. She stumbled upon a team approach to treatment and agreed to continue working with Patrick.

As Suzy described her work and decision-making process with Patrick, she referenced Patrick's approach to treatment as cooperative, active, hard-working, and

diligent. When asked what she learned about herself in doing the CMT, she did not as much talk about herself as she did about how Patrick approached the process:

> I don't want to give myself so much credit for [Patrick] being where he is now because I know I'm [just] doing my role. . . . He has put a lot a work into [getting] where he's at right now.

Throughout the face-to-face interview, Suzy indicated her treatment interventions and decision to continue treatment were influenced by Patrick's approach to treatment.

Daniella did not reference her client Lucy's approach to treatment or presentation in treatment before describing the incident that precipitated the termination process. It was this incident, in which Lucy had been violent with herself, that brought Daniella's boundaries of competence concerns to a head. Although the decision to refer was no longer in Daniella's control after this incident and the consequent emergency hospitalization, the details of how to transition Lucy were still partly Daniella's responsibility. Daniella's decision to do four termination sessions and accompany Lucy on her transitional ride to the residential facility was influenced by Lucy's presentation during her hospitalization. The following are Daniella's words describing Lucy's approach to the needed termination and referral:

> The transitional ride was [at the] encouragement [of] my supervisor because I . . . started to [feel like I was abandoning Lucy]. . . . She was so attached to me [and said things like], "Please don't do this to me. Please don't leave me." I felt so bad. She's crying. The hospital was calling me and telling me she was asking for me. So the [transitional ride] helped me get through. . . . She called me twice from the residential facility. She wasn't doing too well there.

Although Daniella did not reference Lucy's approach to treatment and/or their therapeutic relationship prior to hospitalization, she clearly saw Lucy's presentation as a factor in the final steps of her ethical decision-making process with this case.

June did not link her boundaries of competence concerns with her client's presentation and/or approach to treatment. She did link client presentation and approach to treatment with her ethical decision-making process. Although June had worked with Alice over a period of many years, she was faced with a boundaries of competence concern when Alice said she found herself attracted to young boys. June's resolution to continue treatment with Alice was linked to Alice's presentation and the strength of their therapeutic alliance. In musing about her resolution to continue working with Alice, June made the following statements:

> I know she trusts me. . . . I know she would feel abandoned. . . . I would also keep her because she is different than other predators. . . . She has a conscience.

These statements reflect June's understanding of Alice's presentation, approach to treatment, and the strength of their therapeutic relationship. They also demonstrate her consideration of Alice's presentation within her decision-making process.

Participant conceptual maps for the twelve participants with data relevant to this sub-sub-category reveal very few overt indicators about client presentation and/or approach to treatment. Only two of the maps contain symbols directly referring to the material in this sub-sub-category.

Jim and Eva created content symbols that overtly referenced their understanding of client presentation and/or approach as part of their boundaries of competence concerns and/or ethical decision-making processes. Jim's map (Figure 13) contains one content symbol, which is a long rounded triangle located in the second row of content symbols from the top of the map, labeled *Affection for Therapist* that speaks to the client's approach to treatment. Eva's map (Figure 14) contains three content

symbols about Ed's presentation. Two of these content symbols reference Ed's resistance. One is an oval at the top center of the map labeled *Resistance Cultural* and the other is a circle just right of center at the bottom of the map labeled *Client Resistance.* The remaining content symbol is a large oval located at the top right corner of the map labeled *Client Control and Boundary Issues* and contains several Post-it® notes that reference Ed's between-sessions behavior, which, for Eva, added to her understanding of his profile as a resistant client.

It should be noted here that Beth's map (Figure 15) does contain three content symbols that, at a quick glance, appear to address client presentation and/or approach to treatment issues. These three symbols are labeled *Stressors – Bad things that happened to client, Her Ugly, and Her Resolution.* Each of these does speak of the client but neither the label nor the Post-it® notes they contain reflect Anne's approach to treatment. They address her life circumstances and her encounters with DCFS.

Two participants tucked Post-it® notes about their reflections on client presentation and/or approach to treatment content symbols. Bob (Figure 5) tucked the Post-it® notes that speak about Jennifer's in-session silence and between-sessions phone calls in his long rounded rectangular content symbol at the left of his map labeled *Feeling Lost.* Susan tucked Post-it® notes about George's resistance in the top large circle labeled *What Happened.*

The characteristics of this sub-sub-category are the impact of client presentation and approach to treatment on both counselor awareness of boundaries of competence concerns and/or their ethical decision-making process. Client presentation and

approach to treatment affected the decision making-process from the point of awareness of the boundaries of competence concern through the outcome and aftermath/post-outcome. Some client presentations and approaches would be seen as difficult and/or negative. Some client presentations and approach were reported as positive and energetic. It didn't matter what the presentations and/or approaches were, they affected decision making throughout the treatment process.

Counselor Dynamics Sub-Category

The counselor dynamics sub-category contains data that communicate information about participant professional and/or personal self. As participants told their stories, created their maps, and then explained them, it became clear that each brought a sense of themselves to the decision-making process. It was this sense of self, both professionally and personally, that acted to form the therapeutic alliance and make decisions throughout the process. The counselor dynamics sub-category is composed of three sub-sub-categories: (a) counselor as professional, (b) counselor as person, (c) counselor approach to treatment and response to boundaries of competence concerns.

Counselor as Professional Sub-Sub-Category

This sub-sub-category, counselor as professional, addresses the basic training, credentials, and professional development data reported by the participants. Participants were invited to participate in this study based on their status as licensed

counselors in the state of Illinois. Licensure in the state of Illinois requires master's-degree training in specific areas of study related to the counseling profession, post-master's certifiable experience in counseling, successfully completing license-level appropriate testing, and engaging in continuing education. Graduate training and licensure, however, are only the beginning building block of professional formation and identity. Counselors have a number of external resources they can use for assistance in further professional development and support in difficult situations. These resources include various services provided by professional organizations, formal as well as informal consultation forums, and continuing education opportunities including workshops, seminar, post-masters coursework, and an abundance of literature that can be used for independent study and research.

Basic career formation and supports for continued professional development data emerged at various points in the face-to-face interviewing process. Data related to participant formal education during master's-degree training, continuing education experiences, exploitation of literature, and utilization of available resources offered through professional organizations form the counselor as professional sub-category.

Phase one of the face-to-face interview was structured to collect basic data about graduate-level education, license level, and continuing education experiences. Basic data from phase one is reported in the aggregate data section of this chapter. However, throughout the interviews various participants referenced and/or were asked about their academic, continuing education training experiences, utilization of the literature, and professional organization support services related to their decision-making

processes. The data which emerged during the CMT and in response to probing questions generated in phase four are presented in this sub-sub-category along with some participant observations concerning basic data presented in the aggregate data section of this chapter.

During phase one, participants were asked to rank various content areas of their formal education training on a scale of 1 to 5 based on how helpful training content was in relation to their practice of professional counseling. Frequencies of usefulness ratings for training content areas within professional degree programs are reported in Tables 20, 21, and 22. Several of the participants referenced how their formal academic training had helped them or failed them in approaching their selected case situation and resolution. Those comments related specifically to ethics and diagnostic skills training areas.

Ethics training is arguably foundational to the ethical decision-making tasks participants reported in this study. All 14 participants reported having ethics training in their master's degree programs. Eight of the participants ranked their ethics training as helpful. Four of the participants ranked the ethics training within their degree programs as somewhat helpful. Two participants ranked their academic training around ethics as not helpful. It is interesting to note that the two participants who ranked ethics training as not helpful both indicated that ethics was infused throughout the curriculum and not set out as a course specifically designed to introduce and teach professional ethics. The data related to ranking of ethics content area training by

individual participants does not suggest any comparison between ethics training satisfaction and the decision-making process.

Five of the participants made comments related to ethics training in response to probing questions in phase four. The question asked was, "As you look at your map and reflect on this material, is there anything you would like to share with the profession and/or those who train future counselors?" Daniella, Sam, and Beth responded with insights related to their cases and spoke to their own felt needs in the area of ethics training. Susan and Jim made general comments to the profession and ethics.

Susan and Daniella both spoke about the need to know professional "limits." Susan simply said, "I think we definitely need to know limits." Daniella said, "It would be good if it was stressed that there are going to be times, not might be times, but there are going to be times when you will be over your head." As Daniella was telling about her struggles in treating Lucy, she said,

> I started feeling overwhelmed and wasn't sure if was I being an insecure therapist or was I really overwhelmed. I didn't feel like anyone ever really talked a whole lot about that in school. [No one said], "it's OK to be not qualified for a certain situation. It's OK to refer out." At this point, [when I was working with Lucy], I wasn't aware of that. At this point it was like, "You're the best we've got. You got to go out there and you got to make this work."

A desire for more clarity about the reality of boundaries of competence awareness characterized Susan and Daniella's statement to the profession. Permission to have limits was particularly important for Daniella, as one of her struggles as a novice counselor was that she did not believe she had permission to "not know."

Sam's response to the comments to counselor educators question related closely to the specifics of his struggles with his selected client case. Sam said,

> I would have liked more training in [ethical] and legal issues. I don't think I got a lot of practical experience in my training about what's going to happen in the real world of [professional] work. I knew not to get involved with a client, but when it came to a client discussing another therapist, I was thrown for a loop. [I didn't know] what you're supposed to do without hurting another person [especially] if the client might be lying.

What characterizes Sam's comments about formal training is his desire to have had more thorough training about professionally appropriate responses to various client presentations and consequently to ethical decisions.

One of Jim's requests when asked if there was anything he wanted to say to the profession was "a lot more ethics training." He explained that he would have liked more training time devoted to the reality of being in the room by himself with clients. He also wanted more instruction related to sorting out ethical dilemmas. This portion of Jim's comments to the profession is characterized by his need for more practice-based training.

Beth's response when asked if she had any suggestions for the profession was related to the concept of professional power, which is one of the underlying reasons for the development of ethics codes. She said,

> I wish I had been taught the authority of the job, the power you have to use or abuse. I think we were taught very well not to abuse [our power], but I don't think we were taught how to use it to our client's benefit. [As a professional counselor] you have a great deal of authority.

As Beth recounted the story of her work with Anne, she frequently mentioned her angst that she had not known how to advocate for her client. She believed she might

have been able to prevent the negative outcome if she had known her power and known how to use it. A characteristic of Beth's ethical decision-making process was her regret that she did not know her power as a professional.

Three participants referenced a need for more training in diagnostics and use of the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM) (American Psychiatric Association [APA], DSM-IV, 1994) in stating their requests to the profession. Matthew and Susan both reported cases involving diagnostic considerations and elaborated somewhat on their requests. Jim, who earned his degree in the late 1990s, simply said, "I would have liked DSM IV training. I didn't have that class, and I would have liked to have taken it." Matthew explained that he would have liked more training in how medical and psychological diagnosis are interrelated. Susan, who earned her degree long before counselor training typically included a course on diagnostics, said, "I wish I had training in the DSM, not that I would be diagnosing people, but just to have some context to put things in." Each of these three participant's statements is characterized by experience with clients that informs them about their expressed need for more developed diagnostic skills.

Continuing education is a required activity for maintaining a professional counselor license in the state of Illinois and is mandated by the *ACA Code of Ethics* (2005). A number of authors (Anderson, 1996; Berger, 1982; Corey et al., 2003; Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Remley and Herlihy, 2001; Van Hoose & Kottler, 1988; Welfel, 2002) tie continuing education to counselor competence. According Corey, et al. (2003) a component in determining the resolution

of an ethical dilemma related to boundaries of competence issues is the availability of continuing education opportunities when counselors decide to continue treatment.

Activities that are generally considered as continuing education are seminars, workshops, post-master's formal coursework, and independent reading (Remley & Herlihy, 2005). Because supervision and/or consultation are also seen as contributing to the counselor's professional development, they are sometimes spoken of in the context of continuing education (Corey et al. 2003). The discussion of continuing education in regard to participant professional self and ethical decision making in this sub-sub-category focuses on attendance at seminars, workshops, post-master's formal coursework, and independent reading. Brief mention of supervision and/or consultation will be made in this sub-sub-category when relevant; however, a thorough discussion of supervision and/or consultation is presented in the supervision dynamics category.

All participants in this study reported continuing education activity as part of their professional lives. Participants were asked to rate the usefulness of their continuing education experiences using the same rating scale as they had for degree course content areas. Tables 23, 24, and 25 found in the aggregated data section of this chapter report the frequency of usefulness rating for continuing education content areas. There is no relationship between ranking of continuing education content areas and participant ethical decision-making processes.

Only two participants referenced continuing education as part of their ethical decision-making process. Sarah was involved in an extensive multiyear post-master's

training program and made use of this continuing education instruction to select interventions with Carl, and consulted with this group to assess whether or not her perceptions of her work with Carl were accurate. When Matthew finished his phone intake with Franklin's adult son, he immediately went to the Internet with his supervisor to search out and review written information on Franklin's medical condition. Sarah and Matthew share the common characteristic of reporting the use of continuing education modalities in their ethical decision-making processes.

Corey et al. (2003) suggested continuing treatment as an option when counselors encounter situations beyond their boundaries of competence if they engage in further training. Further training includes conferences, conventions, additional coursework, and supervised specialty training that can increase competence in the area of concern and yield feedback to assist counselors in assessing their competencies. Three participants, Suzy, June, and Bill, selected to continue treatment as resolution to their boundaries of competence ethical concerns and the common characteristic they share is that none of them indicated using or intending to use continuing education opportunities in continued treatment with their selected clients.

A number of authors (Forester-Miller & Davis, 1996; Haas & Malouf, 1995; Remley & Herlihy, 2005; Welfel, 2003) recommend reading and researching literature when counselors engage in complex ethical decision-making processes. Matthew is the only participant who referenced independent reading in the course of telling his story about his decision-making process. In going to the Internet Matthew reported that "he needed to do something" and that he "got a lot of information quickly."

Literature research was thus a characteristic of Matthew's ethical decision-making process.

In phase four a number of participants were asked specifically about independent reading practices. Eva was the only participant who responded to the question by indicating she had done independent reading during her reported decision-making process. She responded, "I did some reading on my own. I reviewed some of my materials on adult children, co-dependence, depression, and grief. I just wanted to make sure that I was getting it all." Sam indicated that he did review some of his professional journals after he was fired in an effort to see if he could better understand confidentiality standards related to reported sexual involvement between mental health professionals and their clients. Daniella and June reported they engaged in independent reading as a tool for professional development and/or to address specific client situations they are facing. Bob indicated that he uses literature assignments with his supervisees and attributes this to realizing his need for resources while working with Jennifer. Suzy's honesty about reading, her boundaries of competence concerns, and continued treatment with Patrick was shared in the statements, "It's laziness, to be honest. When I go home, sometimes I think I should read more books about [sexual abuse]. But at other times, it's like [forget] it. I want to [just relax]." The common characteristic of all of these participants is the admission of the value of independent reading and/or research in the literature. However, except for Matthew and Eva, valuing independent reading and/or research did not, for whatever reason, get translated to application in their selected client case scenarios.

National and state professional organizations provide support and advice for members through their ethics committee personnel. And according to Welfel (2002), consulting professional organizations is a potential step in the decision-making process. Only one participant, Sam, reported consulting a professional organization for assistance with his ethical dilemma. The other thirteen participants did not mention professional organizations at any point in the interview. Sam did not contact his professional organization during the process of struggling with his ethical dilemma. After he had been instructed to terminate with Deb, was fired, and served with a subpoena, Sam contacted the National Board of Certified Counselors (NBCC). At the end of the interview, I decided to double-check my understanding of his statement about calling the NBCC and asked, "You did call the NBCC?" He answered,

> I called the NBCC because I was a National Certified Counselor (NCC) as well as a LCPC. I asked to speak to some one and said, "I am reporting myself. Do I need to worry about anything like losing my certificate or even my state license?" He said, "No." [At the end of the conversation], he said, "You really should have gone to your own supervisor, but I don't see any reason why you should receive any [sanctions].

The only common characteristic related to using professional organizations as an ethical decision-making resource for the participants in this study was its absence.

Because it was believed theoretical orientation might play a role in counselor response to boundaries of competences concerns and thus the ethical decision-making process, data related to participant theoretical orientation were gathered in phase one and reported in the aggregate data section of this chapter. Stated theoretical orientation and preferences were reported in Table 30. There is no comparative pattern in theoretical orientation and participant responses to concerns or ethical decision-

making styles. Only one participant, Beth, overtly identified theory as part of the decision-making process. Beth talked about how the client-centered therapy of her supervisor did not work well in the complex situation she faced with Anne.

Participant conceptual maps show very little of the material in the counselor as a professional sub-sub-category. None of the participant maps contain content symbols that overtly reference participant formal degree training and credentials. Daniella's map (Figure 8) does reference her desire for ethics training to include teaching on the reality that counselors can and do have limits. She included one content symbol labeled *Symptoms: Is this my insecurity or was I not qualified for this* that clearly outlines her struggle to have permission to have limits. In the area of continuing education, none of the maps contain content symbols detailing continuing education efforts in the decision-making process. It could be said that Sarah's entire process with Carl was informed by her extensive multiyear post-master's training program. Although the using of varied modalities is clearly outlined on her conceptual map (Figure 3), she does not directly reference the continuing education influence impacting the selection of modalities. Although Matthew and Eva reported independent reading as a part of their decision-making processes, they did not include this component on their maps. Because Sam consulted the NBCC after the decision for resolution was implemented, this consultation was not part of the decision-making process or shown on his map.

The counselor as a professional sub-sub-category pulls together data related to the professional formation and development of participants, which is primarily related

to participant ethical decision-making processes with selected client cases. There is some data included in this category that does not directly relate to the cases selected by the participants for this study. However, these non-case related data do have, in a broader sense, a relationship to the study of counselor ethical decision-making.

The most common characteristic of professional formation is the fact that each participant had earned a master's degree, which formed the basis of their eligibility for licensure. A secondary characteristic related to formal training is the expression by a number of the participants about ethics and diagnostic training. Five of the participants expressed desire to have had more or different ethics content training. Three of the participants expressed a desire to have had more training in diagnosis.

The most remarkable characteristic of participant use of continuing education and professional organizations as a resource in the process of their reported ethical decision-making processes is the scarcity of data related to these resources in the course of the reported decision-making processes. Several participants were asked if supervisors suggested attending a seminar/workshop or doing some independent reading related to their stated concerns. Only two of the participants, Matthew and Eva, indicated any such interventions on the part of their supervisors. However, a number of participants reported wishing their supervisors had suggested increasing their knowledge and/or skill level in their deficit areas. Participants did acknowledge their need for such continuing education activities related to their decision-making processes.

Counselor as a Person: The Counselor's Heart Sub-Sub-Category

Requirements for obtaining and maintaining licensure as a professional counselor are external measurable components. Underneath and woven through quantifiable licensure requirements is the person who holds the license (Remley & Herlihy, 2005). Participants in this study revealed a sense of themselves as "persons" interacting in the process. During the course of data analysis it became clear that counselor character and emotional responses influenced the ethical decision-making process. Discussion of these data is divided into two sub-sub-sub-categories. Data related to how participants did or didn't demonstrate virtue ethics is presented in the virtue ethics/counselor character sub-sub-sub-category. Data concerning participant-feeling responses to clients and client concerns not directly related to virtue ethics is presented in the counselor feeling responses sub-sub-sub-category.

Virtue ethics: Counselor character sub-sub-sub-category. Cohen and Cohen (1999) introduce virtue ethics by stating,

> Virtue ethics looks at moral action within the context of moral agency. As defined by Aristotle, the ancient Greek philosopher, moral virtues are states of character concerned with rational control and direction of emotions. Moreover, such states of character are, according to Aristotle, habits acquired from repeatedly performing virtuous actions. (Cohen & Cohen, 1999, p.19)

Virtue ethics are about the counselor as a person and/or counselor character. The five most commonly agreed upon virtues for counselors are prudence, integrity, respectfulness, trustworthiness, and compassion. Not all of the virtues were demonstrated by all of the participants. Stating that a given participant demonstrated or possesses a particular virtue can be a subjective judgment. Therefore, the data

presented in relationship to virtue ethics, as demonstrated or communicated by participants, will be limited to those incidents that were most overtly demonstrated or communicated by the participants. After each virtue is briefly defined, a discussion of participant data relevant to the particular virtue will be presented.

The first virtue to be presented in this discussion of counselor as person is *prudence*. According to Kitchener (2000) prudence is demonstrated through sound ethical reasoning that translates into solid, yet adaptable, applications in clinical situations. Meara et al. (1996) suggested this virtue includes "appropriate restraint or caution, deliberate reflection upon which moral action to take, and understanding of the long-range consequences of the choices made" (p. 39). Kitchener referred to this characteristic as *practical wisdom*. Although Sarah, Sally, Jim, and Bill all selected action steps to resolve their boundaries of competence dilemmas, which demonstrated solid and practical clinical wisdom with a view to future consequences, their reported rationales were more anchored in clinical perspective than ethical reasoning. All other participants, with the exception of Sam, demonstrated some aspect of prudence that was anchored in ethical as well as clinical reasoning.

Marti, Matthew, Susan, and Eva each selected client cases that had terminated prior to the face-to-face interview. All generated solid, yet adaptable, clinical interventions as resolutions to their boundaries of competence dilemmas and hinted at ethical reasoning in offering their rationales for interventions. Marti selected referral because she believed she could not help Doris any further, and she also believed the agency she was referring to was better able to work with Doris' stated issue. Matthew

explained his desire to research Franklin's medical condition as "I needed to find out some information about [this medical] disorder before this person arrived in my office." Susan and Eva both selected interventions to continue treatment while at the same time trying to lead their clients to referral. After confronting George about his need for mental health counseling before proceeding with the career counseling she could offer, Susan elected not to terminate. She explained her interventions and rationale as follows:

> [I told him], "I'm not going to refuse to see you because you'll find somebody else and do the same thing." So he did come three or four more times. We were strictly working at that point on just job search process and strategy and plan and trying to help him with the tools and that kind of thing. That's exactly what I told him I would do and nothing more. And by then he got mad. He said, "you're not doing any good. I'm paying all this money and . . . ." I said, "I understand that and I agree. I would still like to refer you because there's a bigger issue here." He stopped coming.

Marti, Matthew, Susan, and Eva demonstrated prudence. All three generated clinical solutions for their boundaries of competence concerns that had solid clinical applications and practical wisdom. Each offered rationales that can be understood as grounded in clinical and ethical reasoning related to their understanding that practicing outside one's boundaries of competency is unethical.

Suzy and June each decided to continue treatment and, in doing so, demonstrated prudence. Suzy had decided on continued treatment as her resolution prior to the face-to-face interview. June decided to continue treatment in the course of her face-to-face interview.

Suzy created a team therapist treatment plan for Patrick. Patrick presented with schizophrenia. Suzy reported being very comfortable with the diagnosis of

schizophrenia and felt she was competent to do the work. However, several sessions into their working together, Patrick revealed he was a sexual abuse victim. Suzy described her reaction and consequent thinking, saying,

> When I found out about that, [I knew that was] beyond what I could do. Because I don't have any special training in [sexual abuse recovery], [I] didn't feel comfortable working with him. [Then] I found out that he actually had another therapist that he sees just for [sexual abuse issue]. He sees this other therapist once a week and only focuses on the sexual trauma. So, we work as a team now. He has me to work on kind of day to day symptoms, the depression and the schizophrenia. When he sees his other therapist to work more on the trauma. I knew right away - when he said he had another counselor - I felt pretty safe with that. So at that point I knew I just needed to talk to the other therapist and just let him know that I'm seeing [Patrick] as well.

Suzy was able to ground her resolution for continued treatment in sound ethical reasoning that spoke to a knowledge of her limits, her creative clinical thinking, and her subsequent careful clinical management of the team approach to treatment. These components combine to demonstrate prudence.

June's boundaries of competence issue with Alice emerged in the midst of a long and well-established therapeutic relationship. June came to her resolution to continue treatment with Alice during the face-to-face interview. She made a number of comments throughout the interview that shed light on her ability to select interventions based on sound clinical and ethical reasoning:

> Within that last month I've tried to broach the topic [of her attraction to young boys] with her again and she's been avoiding it. I have been thinking about sending her to somebody who deals with these kinds of issues, but I'm not quite sure what I'm going to do yet. . . . I know that I am thinking about keeping her. These are the reasons why, because I know she has not sexually abused anybody, She's attracted to 12-year-old boys, but, of course, she would never do anything like that because she knows how horrible that would be. I know that she has her own struggles – which [are] a little bit different than a sexual predator. That's the reason why I would keep on working with her. The part that makes me

> uncomfortable is [my awareness that] I have a bias against sexual predators or people who are thinking about sexually abusing children. That's the personal issue. And the other issue is that there might be somebody out there who could better deal with this with [this material]. The only thing is that we've worked together for quite a long time and I know she trusts me. I'd be concerned about [making a referral which she might not follow through on] because she definitely needs treatment not just for that issue but for other issues. . . . I'm not sure yet what I'm going to do. I'm torn.

All of the above comments were made during the conceptual mapping task (CMT) in phases two and three of the interview. During phase four June was asked if the exercise helped her understand her own decision-making and treatment strategy process. She responded,

> Yes, I can see that I am going to keep her. Yes, I will keep her because it's my issue, not hers. It's her issue but it's [really] my issue that would make me refer out.

As June worked her way through the face-to-face interview, she demonstrated her ability to generate clinical solutions grounded in solid clinical and ethical reasoning. As she moved in and out of her ethical reasoning, she considered the strength of their therapeutic relationship, the trust Alice had in her, and the work Alice still needed to do.

Bob, Daniella, and Beth were experienced clinicians at the time of the face-to-face interview but reported situations from their novice years that ended in termination. As experienced counselors, each shared their perspectives on clinical management and, in hindsight, assessed their selected client cases. All three clearly presented as counselors who could select solid yet adaptable applications in clinical situations using practical wisdom anchored in sound ethical reasoning. Bob and Beth selected client cases that were embedded in clinical settings that provided negative or

neutral supervision and were described as mental health service agencies with problematic system dynamics. These system dynamics are more thoroughly discussed in the system dynamics category. In contrast, Daniella's selected client case was embedded in a system that provided excellent supervision and, from Daniella's report, appeared to be well ordered.

As Bob related the story about his work with Jennifer, it was clear that he, as a novice counselor, had neither the training nor experience to generate solid alternative treatment interventions to help Jennifer with her difficulties. However, he did know enough to seek assistance. Unfortunately, when he sought out direction from his supervisors, he was met with little helpful insight and a lot of confusing messages. As the interview proceeded, Bob demonstrated how he, as an experienced counselor and supervisor, would deal with assisting supervisees to generate and implement solutions to difficult clinical situations based in ethical reasoning.

Beth reported a situation that was ultimately resolved by others; and thus, there was no opportunity for her to demonstrate her capacity for generating solid clinical alternatives. Although Beth did not control the outcome of her work with Anne, she knew she was beyond her competence. She sought direction from her supervisor but reported the supervision as non-directive and not particularly useful. Beth reported feeling powerless to confront the systems surrounding and impacting her treatment with Anne. During the face-to-face interview, Beth explained that since her experience with Anne she has become an advocate for her clients and feels empowered to confront systems she believes neglect or harm her clients. She explained her

experienced counselor perspective on advocacy and in hindsight was able to create a solid clinical alternative treatment intervention for Anne. She said,

> I was the only person in the system [that] cared about the parent who abused the kids. The only person who looked out for what might be in [the parents'] best interests. I could have worked harder to try to advocate for her with DCFS. When I realized what was happening, I could have very easily advocated for her to get in-patient [treatment].

Beth, as an experienced counselor, had developed the professional wherewithal to generate clinical alternatives. Her reference to looking out for "what might be in [the parents'] best interests" hints at her ethical understanding of the ethical principle of beneficence. Beth's ability to generate solid clinical alternatives coupled with her ethical understanding demonstrates prudence.

Daniella's process of resolution to her boundaries of competence issue was well grounded in her supervisor's clinical and ethical reasoning. When Lucy violently erupted during a session, Daniella was confronted with her lack of competency. Although Daniella did not know the specifics of how to proceed with Lucy, she did know to call her supervisor. From the point at which she called her supervisor to her final contact with Lucy's family, Daniella reported a willingness and ability to follow good clinical instruction. Daniella demonstrated practical wisdom and thus prudence through her supervisor-led termination process with Lucy and in her report of the clinical work she was doing at the time of the face-to-face interview.

Marti, Matthew, Susan, Eva, Suzy, June, Daniella, Bob and Beth demonstrated the virtue of prudence during the course of their face-to-face interviews. Each offered reflections about her or his clinical interventions and/or ethical decisions that can be

understood as grounded in clinical and ethical reasoning. Their solutions demonstrated practical wisdom as they included elements of caution, deliberate reflection, and understanding of the long-range consequences of their choices. These are the characteristics of prudence.

The second virtue to be presented in this discussion of counselor as person is *integrity.* According to Remley and Herlihy (2005), integrity involves actions that emerge from a belief in what is right. Kitchener (2000) suggested that those who cannot be counted on to keep their word or uphold moral values, as well as those who act in bad faith or deceive themselves about motive, are said to lack integrity. Integrity requires that one's commitment to doing what is morally best remain consistent and unwavering even under pressure or adversity (Kitchener).

All but one of the participants clearly spoke up about what they thought was right for their clients. Testing their integrity about what they thought was right against the actions that emerged from their beliefs is a bit less clear-cut. Sarah, Marti, Matthew, Suzy, June, Susan, Sally, Eva, and Bill all selected clinical situations in which they had the freedom to decide what was right and to initiate the actions that emerged for them out of that belief. Daniella selected a case that was being very closely supervised, and when she knew she was over her head, she immediately knew it was best to call her supervisor, who then became the primary clinical decision director. Bob, Jim, and Beth all selected client case situations in which they knew something other than what was happening was right, but they were each without the ultimate power and/or knowledge to effect the changes they desired.

The nine participants, Sarah, Marti, Matthew, Suzy, June, Susan, Sally, Eva, and Bill, who had situational freedom to decide on and implement actions they believed were clinically right all demonstrated integrity. Their beliefs about their boundaries of competence limitations and the subsequent actions they took are listed below.

Sarah knew she did not have the physical strength to assist Carl with the expressive work she believed he needed to do. She sought out a referral she believed would be right for Carl and suggested the referral to him.

Marti reported that during the course of her work with Doris she began to think she "couldn't go any deeper with her." Based on her belief that she "couldn't do anything more" for Doris, she sought out an agency that specialized in Doris' particular concern, obtained materials for Doris about that agency, and made sure Doris had received the materials.

Matthew knew he was beyond his boundaries of competence when he learned of Franklin's medical disorder and the age differential between him and his new client. He believed he could find information and insight in doing research on the Internet and took the necessary steps to inform himself. He also believed his supervisor, who had vast experience with the elderly, could inform him about the medical issue in question and offers some insight into working with the age differential, and consulted her on both points.

Suzy knew she was beyond her boundaries of competence when Patrick presented his history of sexual abuse. She stumbled upon the fact that he had another

therapist who worked with him on these issues and then took steps to coordinate a team approach to treatment.

June was uncomfortable with the material Alice presented in regard to her sexual thoughts about young boys and used her interview time to sort out her position. She approached the interview with honesty and a readiness to act upon her discoveries. When she concluded she would continue to work with Alice, she gave herself instructions about what changes she would need to make in order to do so.

Susan articulated the importance of virtue ethics and counselor integrity at the end of her interview when asked if there was anything she would like to say to the profession. She responded as if she was addressing novice clinicians and/or counselors in training:

> There is no place to determine [you are] beyond your limits. It becomes just a part of experience, intuition and certainly some study. [Ethics are] more about who you are than the training you've had or what it says in an ethics book. It's who you are. You know you and you know your limits and you have integrity about that.

Susan knew that, as a career counselor, she could not do the mental health work she believed George needed to do before he would successfully reenter the world of work. She decided upon an intervention strategy to work toward making successful referral for George to a mental health counselor. She was unsuccessful in convincing George to engage with a mental health counselor but knew what she believed and acted accordingly.

Sally reported two situations involving her boundaries of competence in her work with Gail. In one situation she had to make an on-the-spot decision and in the

other she had time to consult, research, and reflect. In the first situation she acted upon her integrity in honoring her client's autonomy and checked with her supervisor later for insight. In the second situation she wanted to use an innovative intervention technique but believed she might be beyond her competence in using it. She consulted two supervisors and followed through on the advice she received to do some research and thinking.

Eva was engaged in grief work with Ed but, as time moved on, believed he needed more than grief counseling. This additional work was beyond the mandate of her agency and she believed possibly beyond her competencies. She consulted her supervisor regularly about her work with Ed, did some reading around his non-grief issues, and took steps to give him a choice of referrals.

The case Bill selected for his CMT was a current case and it was during the interview that he reached his decision to continue treatment. Bill was a pastor and Ray, his selected client, was a member of his congregation. He believed that he might be beyond his boundaries of competence with Ray, but was not sure. Based on his concerns about his boundaries of competence and his beliefs about the limits of his working environment, Bill developed a plan that included specific actions that would assist him in clarifying how to proceed with Ray.

Sarah, Marti, Matthew, Suzy, June, Susan, Sally, Eva, and Bill all shared three common characteristics relevant to the virtue of integrity. They each (a) identified their boundaries of competence concerns, (b) put forward the actions they believed were right based upon an understanding of their professional limits, and (c) either

carried out their action plans or made clear actions plans to address their concerns. Each of these participants communicated and demonstrated integrity.

Daniella knew she was over her head when Lucy became violent in a session. It should be noted that, although she did not know what clinical action to take, Daniella did know when she was beyond her boundaries of competence and knew how to reach out for help. When Daniella initiated an emergency call to her supervisor asking for assistance, she was no longer the primary clinical decision-maker but a teachable student. She knew calling her supervisor was the right thing to do and followed the directions she was given with competence. Daniella's decision to call her supervisor, willingness to follow her supervisor's instructions, and eager acceptance of her supervisor's support all emerged out of her knowledge of what was right and thus, she demonstrated integrity.

The three participants who demonstrated integrity and selected client cases from settings where they did not have ultimate control over the outcome were Bob, Jim, and Beth. Bob and Beth were experienced counselors at the time of the face-to-face interview but novice counselors at the time of their work with Jennifer and Anne. Both Bob and Beth reported knowing that different actions should have been taken in response to their client concerns. However, neither of them had the knowledge or power to effect a change at the time of their work with Jennifer and Anne. Bob believed it was right to seek counsel from his supervisor, he also knew there was something wrong with the supervision situation around him. He did not have the training to know what to do on his own nor did he have any power in the system to

effect the changes he believed were needed to address Jennifer's situation more effectively. Beth knew that she was over her head with Anne and sensed chaos within the social systems serving Anne. She later came to believe this system chaos added to Anne's negative circumstances. Beth clearly communicated her belief that she had not been given the tools she needed to develop an action plan on her own as a novice counselor.

As novice clinicians, neither Bob nor Beth had the training or power to develop solutions they could believe in or be committed to in the circumstances surrounding the cases they presented. Both were distressed by the circumstances of their selected cases. However, they both clearly demonstrated integrity in their commitment to pursue vigorously professional development opportunities that would give them the foundations they believed were needed to be quality clinicians. At the time of the face-to-face interview they both clearly articulated insights about what they believed should or could have been done differently with Jennifer and Anne.

Jim knew what he believed needed to happen in his case with Mary and developed an action plan. Jim's plan was referral, but he did not have the power to implement what he believed was right for Mary. It was Jim's supervisor who held the power to reassign Mary's case. Jim's belief in his need to refer Mary kept him persistent in requesting a referral for Mary until his supervisor finally approved. It is Jim's belief in what was right and his persistence in requesting his plan be implemented that demonstrated his integrity.

Sam is the one participant who did not clearly speak about what he thought was right in regard to his client case. Sam presented a very confused picture about what he believed he should have done in managing the information Deb gave him about her sexual interaction with other mental health service providers. His confusion was most apparent in his post-outcome reflections. Sam had been subpoenaed for a deposition related to Deb's case. In his description of the deposition, he summarized his struggle and indicated his lack of clarity:

> I attended a deposition where I was the only witness with three lawyers. They asked just a lot of questions about the situation and my character. At the end they asked "did you believe Deb about the sexual incidents with the agency caseworker or not?" Either way I should have reported it. I really, never knew what to believe. I just put it away and I didn't want to get into trouble. And thought that with my report to his supervisor I had covered myself but there was something with not reporting to my own supervisor that I knew was not right. I felt it the whole summer. And that was what wound up getting me fired. That's the end of my ethical dilemma. It's affected my confidence in myself. I lost a job.

If, as Remley and Herlihy (2005) suggest, integrity involves actions that emerge from a belief in what is right, Sam did not demonstrate integrity in his decision-making process with Deb. Sam, according to his own report, did not have a clear sense of what was the right action to take in this situation.

There are two broad and common characteristics of all the participants who demonstrated integrity in the decision-making process. First, they either had a belief about what was right for their selected clients or they developed a professional knowledge base that informed them about what would have been right in dealing with their selected clients. Second, they demonstrated the ability to develop and implement actions emerging out of their beliefs about what was right.

The third virtue to be presented in this discussion of counselor as person is *respectfulness*. According to Kitchener (2000) and Meara et al. (1996), the virtue of respectfulness is a willingness to extend to others consideration for their concerns, wants, needs, and perspectives. They suggest a lack of respectfulness may manifest as racism, sexism, and/or other forms of intolerance. Remley and Herlihy (2005) pointed out that this virtue is sometimes termed "self-awareness" related to counselors knowing their own beliefs, persuasions, and biases. All participants presented their client circumstances and struggles with remarkable respectfulness.

It would be rather impossible to pick out specific words or phases from participant transcripts to illustrate participant enactment of the virtue of respectfulness. Each participant spoke about client concerns, wants, needs, and perspectives as points of consideration in the decision-making process. Each participant presented her or his decision-making process in a way that communicated a real desire to meet the client where he or she expressed a need for growth and/or assistance. For Sarah, Marti, Suzy, Daniella, and June it was their client's stated and/or demonstrated need for change in a given area that surfaced their boundaries of competence concerns. It was as if they were each saying, "I hear this client's concerns, wants, and/or needs and I don't know if I have the ability to help them with those particular difficulties."

It might be easier to explain participant demonstration of the virtue of respectfulness by stating what they did not do or say. There is not even a hint of prejudicial actions or attitudes, such as racism, sexism, and/or other forms of intolerance, in the interview transcripts or in the non-verbal communications of

participants. There were no off-handed jabs about client circumstances, no intolerance for their life choices, no half-hearted efforts to work toward reliving client distress.

A common characteristic of all participants in this study is the demonstration of the virtue of respectfulness. In relating their client circumstances and concerns participants expressed consideration for client concerns, needs, wants, and perspectives in a way that extended dignity to each client. As participants explained and/or worked through their decision-making processes, they consistently spoke of their clients in respectful tones.

The fourth virtue to be presented in this discussion of counselor as person is *trustworthiness*. According to Beauchamp and Childress (2001), the trustworthy counselor is a conscientiousness professional who is "motivated to do what is right because it is right, has tried with due diligence to determine what is right, intends to do what is right, and exerts an appropriate level of effort to do so" (p. 37). Counselors who possess the virtue of trustworthiness are virtuous agents who are known to have solid character and generate confidence in their capacity to be trusted by society, colleagues, and clients (Cohen & Cohen, 1999). Whether a participant has generated confidence in his or her capacity to be trusted by society, colleagues, and clients is beyond the data collected in this study. Therefore, assessment of trustworthiness was based only on participants' report of their own motivation to do what was right because they believed it was right and their commitment to expend energy to implement action they believed to be right.

Data on participant motivation to do right and actual energy expended to do right require a degree of subjective judgment and is hard to quantify. It is easier to say what was not there than what was there in regard to trustworthiness. With one exception, the participants in this study did not present any data that refuted their trustworthiness. Sam is the exception. Although Sam spoke of wanting to do what was right, he also indicated that he was too lost in his internal conflict to do the diligent work needed to determine what was right. All of the other participants presented data that indicated they were conscientious professionals, motivated to do what they believed was right, and willing to exert the appropriate level of energy to do what they determined to be right. Generally speaking, given the limits of the data, it can be said that trustworthiness is a characteristic demonstrated by all but one of the participants.

The fifth and final virtue to be presented in this discussion of counselor as person is *compassion.* The virtue of compassion or care, according to Beauchamp and Childress (2001), is "a trait that combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness, and discomfort at another's misfortune or suffering" (p. 32). The words in the Beauchamp and Childress definition that are particularly relevant to the reported ethical decision-making processes of participants in this study are: "active regard for another's welfare," "tenderness," and discomfort at another's misfortune or suffering." Remley and Herlihy (2001) labeled this virtue as "acceptance of emotion" (p. 8) and argued virtuous counselors understand emotion has a role in ethical decision making. Kitchener (2000) contended compassion or care ethics require counselors to balance

virtue and principle and argued that compassion requires integrating interventions based on ethical principles with compassionate understanding of situational factors without neglecting principles. Beauchamp and Childress pointed out compassion differs from integrity, because compassion is "other-focused" and integrity is "self-focused."

There is some evidence in each of the transcripts that implicitly or explicitly speaks to participant compassion or care for their clients. The client background sub-sub-category in the client dynamics sub-category of the therapeutic relationship category contains significant discussion on the dynamic of human care with which participants presented client background and life situations or circumstances. Each of the participants overtly expressed a regard for their client's welfare.

The Beauchamp and Childress (2001) definition of the virtue compassion includes the idea of this regard for client welfare as being "active." Although all participants expressed regard for their clients' welfare, not all of them did so in a manner that could be seen as active. Sam expressed regard for Deb's welfare in the process and timing of the agency-required termination, but he did not seem to have the tools and/or drive to put any action or activity behind his regard during the course of the story he told. Given that June and Bill both appeared to use the interview process as a consultation opportunity, neither had developed an action plan for the resolution to their boundaries of competence concerns prior to the interview. However, both developed plans during their interviews that declared intent to implement interventions that would demonstrate regard for their client's welfare. All of the other participants

took action, some more full of energy then others, that could be understood as "active regard" for client welfare.

According to Beauchamp and Childress (2001) the active regard of compassion is combined with tenderness. There was a tone of tenderness in the spirit in which a number of participants talked about their selected clients. The participants that particularly stand out in this area are Matthew, Suzy, and Daniella.

Matthew expressed his tenderness for Franklin in his voice tone and body language as he reported his care and concern for his client. Several times, as he described his concerns for Franklin, Matthew did this very distinctive motion of cupping his hands together and gently moved them up and down. As he did this, he appeared to be as if holding something very precious. In this way Matthew demonstrated a tenderness associated with his care and compassion for Franklin.

Suzy spoke tenderly about Patrick and her work with him. At one point, in her work with Patrick, he was hospitalized and she reported her phone intervention as follows:

> The last time he went to the hospital, I called him, just to see how he was [doing] in the hospital. And he's like, "When you called me that felt so good. I'm so happy you called me."

As she related this intervention, she had this very tender tone in her voice that was accompanied by a facial expression of soft eyes and tender smile. These same facial features reappeared when the researcher reflected to her, "You really like him," and she responded, "I do. I do." Through these facial features and voice tone Suzy communicated her tender compassion about Patrick and his circumstances.

Daniella's tenderness was most evident as she related her compassion for Lucy's parents. At one point in the interview Daniella explained that Lucy's "parents had no way of controlling [their daughter]." At this point and throughout the interview Daniella demonstrated a tender compassion for these parents, who she later understood were trying to deal with a very difficult problem that was likely biologically based. After Lucy was hospitalized and later moved to a long-term residential facility some distance from the family, Daniella met with the parents twice:

> I had my supervisor join me so that she could better explain the disorder [given to Lucy by the hospital staff] . . . . Asked my supervisor to join me so that she can technically explain what was going on with their daughter. [I just] supported the parents. They had to deal with the fact that they had lost their daughter to a residential program that was four hours away. They couldn't even see her all that often.

Daniella's tender compassion for Lucy's parents was demonstrated in the care she took to help them through their loss and was expressed in the interview with tenderness demonstrated in voice tone and affect.

Application of the Beauchamp and Childress (2001) definition of compassion also includes the notion of counselor discomfort over the "misfortune or suffering" (p. 32). Suzy, June, Sally, and Jim reported cases in which child abuse was a part of the client background. In each case the participants reported this information in a way that indicated their own deep understanding about the painful impact of child abuse on a child's life. Daniella expressed deep compassion coupled with discomfort for the suffering Lucy's disorder brought to both Lucy and her parents.

Beth's presentation of her client case dominates the study in relation to compassion expressed as discomfort over the misfortune and suffering of a client. This

is especially remarkable given Beth's report that Anne threaten to kill her. Throughout her interview, Beth repeatedly referenced her distress over Anne's suffering. As Beth told the story of her work with Anne and the things she would like to have done differently, there was tremendous energy. At one point Beth was explaining her upset over how DCFS had handled their part of Anne's care. She was talking about how Anne and her significant other, Doug, had been in couples therapy and doing really well. However, Doug abruptly left the relationship and Anne's difficulties increased. DCFS placed Anne in alternative housing, and then took the children away. The following quotes are bits and pieces from Beth's transcript that reveal her deep feelings about Anne's suffering. The italicized words in parentheses are notations describing Beth's non-verbal expressions:

> Yeah, I considered them my success story too. They were doing so well. She was doing really good with her parenting stuff. That's the tragedy. . . . It was hard because he was a support for her. [She became homeless] and I think being homeless really pushed her over the edge. . . . And [DCFS] put her in the local fleabag hotel. And who hangs out at the fleabag hotels? Drug dealers. I think she might have been getting into some prostitution too in order to survive. . . . She was hanging out with all the drug dealers and the druggies in town. . . . She grabbed my heart. She's bright, she's beautiful, and the kids were wonderful. [Then they] they took away her babies. They never even told me they were doing this. They never let me know. *(She sounds biting angry)*. It came out of the blue. They took away her kids. *(Sigh of disgust)*.

> What happened to me as a consequence is that I changed how I viewed my job and I gained a deeper understanding of the seriousness of mental illness. I mean these folks have nothing . . . nothing . . . nothing. There was this other young woman. I heard her stomach growl [in session]. She was like 16 and out on her own. [I asked], "Are you hungry? When was the last time you ate?" [She said], "We had a can of green beans and some mashed potatoes yesterday. Now we're out of food." How can you do therapeutic work with her? So we were all going out to lunch, and I took her with us to Pizza Hut. I have never seen anyone eat so much on a pizza buffet in my life. And we got her food. I had a good relationship with my food pantry people. I called and got her food. I'd give her

> money. Do they cover that in ethics? So what do you do when they don't have any food? You hand them ten bucks. Sometimes you do. Nothing to eat. Food pantry's closed. I always hid a couple of tens in my wallet. 'Course that was long enough ago when ten dollars did buy you food.

Beth articulated her compassion for client suffering in word and action. She also spoke about her feelings of distress concerning the circumstances Anne and this other client found themselves in. All of the other participants, in some discreet way, expressed some measure of compassion for their client's misfortune and/or suffering.

There are two remaining components of the virtue of compassion. The first is how the virtue of compassion involves the acceptance of emotion as part of the ethical decision-making process (Remley & Herlihy, 2001). The second is the need for balancing virtue and principle ethics (Kitchener, 2000). It is clear throughout the transcripts that participants were emotive and made no obvious effort to eliminate emotions from their stories. Additionally, the participants seemed to weave emotional responses freely, without apology, into their stories of ethical decision-making processes. However, beyond accepting emotion as a natural part of the ethical decision-making process is the question of whether or not counselors understand the role counselor emotion plays in informing and/or impacting the process. Kitchener argued for the balancing of virtue and principle ethics in ethical decision making. There is no evidence in the data gathered in this study as to whether or not participants consciously understood how their emotions informed and/or impacted the decision-making process. There are also no data to affirm or deny that participants consciously balanced compassion and principle as they selected resolutions for their boundaries of competence dilemmas.

All of the participants expressed compassion in one or more ways. A common characteristic that can be seen throughout the face-to-face interviews is participant expression of care and regard for their clients. Some of the participants expressed their compassion with noticeable energy and emotions but others presented a more subtle sense of caring for their clients.

As might be expected, participant maps do not offer many overt symbols that speak directly to participant virtue. However, when the maps are viewed as a whole picture of the process and not just individual content symbols, Post-it® notes, and flow lines, there is an overall demonstration of prudence and integrity in a number of the maps. The solid, yet adaptable, applications of clinical solutions coupled with practical wisdom can be seen in the maps created by Marti (Figure 4) and Suzy (Figure 7). Beth's map (Figure 15) can be divided into two rows, with the top row being about Beth and her process and the bottom row being about Anne and her concerns, wants, needs, and perspectives. As with Jim's map, when the viewer understands Beth's heart as revealed in her story of ethical decision-making, this bottom row containing symbols labeled *Stressors-Bad things that happened to client, Her Ugly, and Her Resolution* can be viewed as representing Beth's demonstration of the virtue respectfulness. The virtues of trustworthiness and compassion, although demonstrated by the participants, are not directly demonstrated in any participant maps.

The virtues of prudence, integrity, respectfulness, trustworthiness, and compassion were all demonstrated by the participants in this study. Nine of the participants demonstrated prudence in their reported therapeutic interventions. They

demonstrated sound ethical reasoning, offered solid clinical solutions for clinical and/or ethical concerns, and gave evidence of understanding the long-range consequences of their choices. All of the participants demonstrated integrity and respectfulness. Trustworthiness was demonstrated by all but one of the participants. Trustworthiness includes the notion that society, colleagues, and clients trust an individual to perform her or his professional tasks, as well as an internal motivation to do what is right and the demonstration of determination to apply actions determined to be right. Measuring societal, collegial, and client trust in participants was beyond the limits of this study. However, all but one of the participants demonstrated an internal motivation to do what they believed to be right and exhibited a determination to apply their selected actions. All participants demonstrated compassion. Because Sam only demonstrated two of the five virtues, his status as a virtuous therapist, based on this particular interview exercise, is in question. All of the remaining participants presented themselves as virtuous therapists.

Counselor feeling responses sub-sub-sub-category. Data related to participant feeling responses and emotional engagement in the clinical process, which are not principally relevant to virtue ethics, are presented in this sub-sub-sub-category. Although the virtue of compassion deals with counselor emotion, it narrows the discussion of counselor feeling responses to the various dimensions of compassion related to client welfare. The discussion of counselor feeling responses covers a wide range of emotional expression and clinical circumstances. Participants reported feeling responses related to their clients as people, the clinical circumstances in which their

client cases were embedded, the process of decision-making, and outcome. Some of these emotions revealed the internal conflict experienced by participants as they worked through sometimes difficult and/or confusing circumstances.

From the first to the last interview conducted for this study it was apparent and even striking that these participants are human beings engaged in relationships. The relationship participants described were clinical, and yet, somehow involved a distinctly human and interpersonal exchange of feelings and reactions. Participants told their stories with feeling and a genuine passion that only comes from the human heart as they discussed the ethical decision-making processes they described and the clients with whom they worked. The presence of professional reaction, balanced with genuine person-to-person emotion, is evident throughout the 14 rich stories of ethical decision making. Words on paper tell a good part of the passion that was expressed by these participants, but they don't always fully capture the essence of the deep feelings presented in the interviews. I left many of the interviews struck by the emotion-filled stories I had just heard. Many of the interviews were infused with an emotional energy that was intangible and hard to scientifically measure, yet incredibly real, powerful, and repeatedly present in voice tones and visible in body language. Time and again as I listened to participants tell their stories, I felt like I was in a sacred place listening to professional counselors share feelings that came from the core of their beings.

Documenting all of the data demonstrating participant verbal and non-verbal feeling responses would be entirely too lengthy a process for this written report. Because their interview presentations were particularly full of both verbal and non-

verbal feeling responses, Bob and Beth's interview data have been selected to highlight participant feeling responses. However, before presenting data related to Bob and Beth's feeling responses, a few brief sketches are reviewed here to illustrate the pervasiveness of participant feeling responses during their reported ethical decision-making processes.

During the interview with Sarah it was apparent she had lots of energy and enthusiasm about clinical work, including her work with Carl. This energy and enthusiasm filled the conversation with a noticeable excitement. At one point in the interview Sarah spontaneously gave a little speech about her joy regarding the privilege of doing clinical work. She said, "It's a blessing to work with my clients. It is such a gift. They work through such [deep] stuff. It is so wonderful to work with them." Sarah's enthusiasm and energy were feeling responses, which she demonstrated as a part of her ethical decision-making process and clinical work with Carl.

Suzy, Sally, and Eva also demonstrated joy and a satisfaction about their clinical relationships. Suzy's facial expressions told the story of joy as she reviewed Patrick's progress from "zombie" with "flat affect" to an individual who was engaged in life. Suzy said, "now he's got a life and he's got friends." Suzy was very alive when she said this and very excited for her client. Sally also was animated and joyous as she described her client's progress in counseling. In reference to the time when Gail's mother joined in on a counseling session, abruptly left the session, and then returned,

Sally said, "I was glad she came back." Suzy and Sally demonstrated an emotional response to their selected clients' process and progress.

Eva demonstrated and verbalized her passion for grief work. She spoke with energy as she was talking about Ed's resistance to her interventions and then spontaneously offered her perspective on "cultural resistance to the grief process." She said,

> There is cultural resistance to the grief process. We don't grieve. The first [thing] we don't do in this country is we don't get old. Second, we don't get sick. Third, and finally, we don't die. When you do [encounter] death, you get three days off. That is mandated. Then you're over it.
>
> Where my passion is and where my energy goes in my work is in the educational part and in encouraging people. [I want] to let them know that this room is their place where they can come and grieve.

Eva laced her passion and energy for the process of grief work throughout the story of her ethical decision-making process and work with Ed.

Bill's feeling responses ranged from joy and satisfaction to deep concern. As Bill was describing his map and the energy he finds in the therapeutic process, he laughed as if he was experiencing great joy just reviewing the work he had done with his selected client, Ray. At one point in treatment, Bill had a session with Ray's wife. As he was relating Ray's wife's detailed description of the dynamics operative in Ray's family of origin, he said, "It felt awful to me." Later he talked about his concern for Ray in deep and thoughtful tones and said, "I'm concerned about him. I am very concerned about him." Bill's feeling responses to his selected client were demonstrated in a deep concern for Ray and his wife and great joy about their therapeutic process.

Bob, Matthew, Daniella, and Jim all spoke of feeling overwhelmed and/or lost. Bob's story, which will be given a more thorough treatment later in this sub-sub-sub-category, laced with his feelings of being overwhelmed and lost while working with Jennifer. Matthew spoke about using his knowledge of basic counseling skills to ground himself during his work with Franklin, but acknowledged that he "still felt overwhelmed" and that it "was an intense case." Daniella stated, "I started feeling overwhelmed" and asked, "what did I get myself into?" When Jim's supervisor resisted his request that Mary's case be transferred, he reported not knowing what to do and felt lost. Overwhelmed and/or lost are feelings reported as part of the ethical decision-making process by all four of these participants.

Bob's story was emotionally full. Parts of it were hard to listen to, type, and/or read because of Bob's gut-wrenching emotional responses. His feelings of angst are woven throughout the client selection and conceptual mapping task. He frequently referenced his feelings saying things like, "I was feeling very lost and confused." Later in the interview he said, "I was confused. [I was] lost. I felt fully overwhelmed and worried I had just messed up. [I felt] ineffective and unable to effect change. I felt totally lost." At another point in the interview, Bob again referenced his feeling of being lost, saying, "I went through probably 3 to 4 years of being very lost with this client – not knowing what I was doing."

Bob talked about experiencing feelings of panic when Jennifer would place phone calls from unidentified locations saying she was suicidal. He described his inner experience:

> Sometimes [she had a] plan and I would be totally overwhelmed. I was usually drenched in sweat after an hour and then she would hang up. Usually I could get her to guarantee [that she would see me at the next appointment] and [would agree to] call me before doing anything to harm herself. I would usually get a "yes" or a "maybe" and then she would hang up. I would be unable to sleep for the rest of the weekend, or the rest of the night. Is she going to show up? I have no way of tracking her down.

Bob reported that when he would seek out supervision he would get "no answers." He said, "I felt totally lost" and stated,

> I can remember sitting on the steps to the building where we were at and just feeling like I needed to bang my head on the wall because I didn't know what to do. Going inside to supervision and feeling no one was really being very [clear]. Everybody seemed ambivalent.

Bob's primary feeling responses to his client presentation and imprecise clinical supervision were confusion, a sense of being overwhelmed, and feelings of being lost. The above quotes from Bob's transcript illustrate his intense feeling responses to his client and the situation he found himself in during that time of his professional counseling career. The story of Bob's ethical decision-making journey with Jennifer was laced with his feelings.

Beth's interview was an emotionally charged and powerful encounter. Her emotions included pain, sadness, anger, scare, and empowered compassion. Although this sub-sub-sub-category is limited to feeling responses not directly related to the virtue ethics sub-sub-sub-category, Beth's compassion was so completely interwoven with the other emotional responses she reported that it seems important to at least note it again.

Beth talked about the outcome of her decision-making process with Anne as being painful and sad. Anne, in a psychotic state, had threatened Beth's life along with

several others in agencies that had provided her social services. The following quotes, taken from various points in the interview, detail some of her feeling responses to the death threats, the outcome, and her internal reaction to Anne:

> It's really painful for me because I felt like I failed her. She lost her kids
>
> I felt like a failure [and I experienced] a lot of guilt. It was really traumatic. You don't go into this [business] to have people threaten to kill you
>
> She threatened to kill both of [the DCFS workers] and me. She began calling me in the middle of the night because our number was in the phone book. She'd call in the middle of the night screaming and yelling at me and I was pretty scared.
>
> I have felt so sad for her. I'm really sad. Yeah. And those kids would be all grown up now. They were 8 and 10, I think. They weren't teeny tiny.

Sitting with Beth as she said these words was a powerful experience. As she told the story of how very difficult this experience was, her words and affect were congruent.

During the course of the interview, Beth also talked about her anger. She said, "I remember being angry at times." She went on to explain that the anger showed up when she had to struggle between protecting herself and keeping confidentiality about Anne's treatment. She said,

> I remember being especially angry over the confidentiality piece. You see, it was a terrible moral dilemma for me. What do I? You can breach confidentiality if [someone is] at a risk of harm to self or others. How do we define others? Never thinking until it hit me one day – "other" meant me as well.

Beth was also angry at the deficits in her training. She mentioned this anger on several occasions. At one point Beth said, "I remember feeling pissed off. In my community mental health class we were taught how to build an agency." She went on to explain that she had never needed the skills necessary for building a community agency as a professional counselor and that what she really needed with Anne and

others was the skills necessary in client advocacy. At several points in the interview she referred to her upset about not being exposed to the notions of professional power and the role of advocacy counselors can play for their clients. She stated that it was her work with Anne that awakened her to the understanding that her "job was really to become the client's advocate."

Beth infused her face-to-face interview with emotion. She was not shy in talking about her responses to Anne and the outcome of her work with Anne as feeling responses. Beth seemed to believe that clinical work and the components of ethical decision-making are intricately and naturally interwoven with feeling.

The conceptual maps created by Bob, Sam, Jim, Eva, Beth, and Bill each contain a single content symbol or flow line that overtly identifies feeling responses experienced during the course of their reported ethical decision-making processes. At a glance, it appears that Beth's map contains only one symbol that is readily identifiable as a feeling response. However, when her map is coupled with her verbal description of the map, it is clear that, for Beth, a significant portion of the map is about feeling responses.

Bob's map (Figure 5) contains a long rounded rectangle at the left-hand side of the map labeled *Feeling Lost* that clearly highlights his feelings of being lost with the content and process of his work with Jennifer. The Post-it® notes in the *Feeling Lost* content symbol reference client background and clinical process information as well as Bob's feelings. As Bob was drawing and describing the double-arrow point flow lines labeled *No Answers/No Help* demonstrating the back-and-forth process between the

clinical process and supervision, he said, "I mean it was me [who kept] going back and forth. It became almost like I'm over my head but no one really [has any answers]. [There were] no answers, I felt totally lost."

Sam's map (Figure 9) contains an oval he placed just to the right of center at the top of the map and labeled *The Aftermath.* This content symbol title is representative of Sam's emotionally laden post-outcome experiences with his own inner struggles and encounters with legal matters. Sam reported feeling responses primarily related to his own inner struggles.

At the bottom of Jim's map (Figure 13) there is a rectangular content symbol labeled *Finishing Touch* containing one Post-it® note. That note reads "*Glad to be done,"* and expresses succinctly the joy Jim demonstrated as he finished his story, quickly brushed his hands against one another, smiled, and read the note with an air of exuberance demonstrating his feeling response to being finished with this case.

Eva's map (Figure 14) has one emotionally laden flow line but no content symbols overtly speaking about her feeling responses to Ed or her ethical decision-making process. It is the line encircling her process that speaks of the most emotionally laden aspect of Eva's reported process. Eva described this line as "happy squiggles," which she said represented "the wonderful supervision I had throughout this whole episode."

Bill talked with enthusiasm about the clinical process while describing his map (Figure 16). He described his map as a bowl. The bowl is his conceptualization of treatment that moved into the center of the bowl in an ever-deepening process. In

describing this bowl-like process he said, "In the middle is a lot of energy. That's where I really feel the energy in sessions. Where I really feel that there's emotion and energy." Subsequent to describing this energy Bill placed a single Post-it® note in the center of his map that reads *Energy.*

The map discussion portion of her transcript is permeated with the feeling responses. When Beth moved into the map portion of the CMT, she became very emotionally expressive in voice tone and body language. There was an emotional energy to her descriptions of many of the content symbols in her map. As she talked about the rounded rectangle at the upper left of her map (Figure 15) labeled *Systemic-No control for me or client*, Beth was clearly upset that there was no control for either Anne or her. When she moved to the oval labeled *Stressors-Bad things that happened to client*, I reflected to her that I could hear a great deal care for Anne in her voice. She responded, "She grabbed my heart" and continued to talk enthusiastically about Anne and her children. As Beth talked about the small rounded square at the right-hand side of her map labeled *My Ugly*, she hit the desk and said, "That was me hitting my head out of frustration with systems." Next she moved to the larger rounded square in the top right corner of her map and labeled it *My emotion/cognitions.* She did not elaborate on this content symbol, but on the three Post-it® notes it contains are written words like scared, painful, guilt, and traumatic. As Beth talked about the rounded rectangle labeled *My Shortcomings,* located just to the left of center in the top row of her map's content symbols, she sounded angry and heaved a sigh of disgust. Beth's anger and disgust were linked to the manner in which Anne's children had been taken

away and how she was not prepared as a young clinician to intervene on Anne's behalf.

The non-verbal communications, interview words transcribed into written words, and participant maps all contain the common characteristic of feeling responses to clinical interactions experienced in the ethical decision-making stories of the counselors who participated in this study. These feeling responses demonstrated a wide range of emotions and concerns. A number of participants spoke of and/or demonstrated a notable energy, enthusiasm, and even passion for their professional work. Participants expressed joy and satisfaction related to client progress. Feelings of deep concern, sadness, and anger at outside forces were expressed as participants related client difficulties. Confusion, feelings of being lost, and a sense of being overwhelmed were reported by participants as they described client, supervision, and system dynamics. Emotions played a role in the clinical interactions and ethical decision-making processes of participants in this study.

Counselor Awareness of and Response to Competence Concern(s) Sub-Sub-Category

When participants were asked to tell the story of their journey with a selected client, the interview directions were designed to emphasize the participant decision-making process. The interviewer began with following request:

> I would like you to think of one client case where, in the course of doing individual treatment, you became aware that you had just heard or had been hearing a client concern that was outside of your experience and/or training level.

After participants indicated they had a client in mind, they were given further instruction:

> I would like to ask you to take about 15 minutes to tell me the full story of your journey to resolve the concern you had with this client. I would like you to begin at the point you first became aware of your limits to treat this client and continue your story through the process of continued treatment, the termination, and/or referral of this particular client.

Participants selected a wide range of client presentations and clinical situations. In describing their selected client cases each participant reviewed her or his own response to the client's concerns. The data related to counselor awareness of and response to boundaries of competence concern(s) are presented in three sub-sub-sub-categories. The first presents data related to counselor awareness of boundaries of competence issues. The second presents data relevant to how participants responded to their reported boundaries of competence concerns. The third presents an overview of participant ethical decision-making style.

Awareness of Boundaries of Competence Issue(s) Sub-Sub-Sub-Category. As participants moved through the stories of their ethical decision-making process, they identified their boundaries of competence concerns with varying degrees of preciseness. Matthew, Suzy, June, Susan, and Sally reported a specific point in the treatment process that alerted them to a boundaries of competence concern. During the process of treatment with their selected clients Marti, Daniella, Susan, and Eva reported wondering about their competence to treat, but, at a particular point in time, each reported knowing they would have to address the issue of concern. Sarah and Bill told their stories without ever clearly identifying a time when they knew they were dealing with a boundaries of competence concern. They both reported a general sense

of questioning the rightness of treating their selected clients given skill and/or clinical setting limitations. Bob and Beth reported that as novice counselors they had a general sense that something was not right regarding their selected client cases. However, it is likely neither of them could have clearly articulated exactly what was wrong until some time after their clients had moved on. At no point in the interview did Sam clearly identify his boundaries of competence concern.

Four participants, Matthew, Suzy, June, and Sally reported point-in-time experiences of encountering their training and experience limits. Each clearly identified the issue(s) involved. All of them immediately knew they had to address the issue presented by the client as outside of their training and/or experience level.

Matthew reported becoming aware of his limitations to treat Franklin during his intake phone interview with Franklin's son. He knew immediately that he did not have the level of knowledge he would need to treat his new client given Franklin's medical condition, and he was concerned about the age difference. He said,

> I know how [this medical disorder] naturally affects your body but I did not know really the intensity. So [I started] thinking, "hey, I need to find out some information about this disorder before Franklin arrives in my office." [A second issue] was, "How am I as a 28-year-old energetic man going to help an 80-year-old man, who was probably very grounded in his ways?" I immediately contacted my supervisor and began talking about this issue.

Matthew's identification of his boundaries of competence concerns was immediate and clear.

Several sessions into Suzy's treatment with Patrick she became abruptly aware of her limits in training and experience with sexual abuse cases. She reported that moment, saying,

> When I found out about the sexual abuse, I knew that was beyond what I could do. Because I don't have any special training in incest or sexual trauma. . . . When I heard [sexual abuse history], I didn't think that it was something I could do and didn't feel comfortable working with him [around this issue].

Suzy reported feeling very competent to treat Patrick's schizophrenia, but when he first reported a history of child sexual molestation, she immediately identified this as an area of treatment outside of her competencies.

June worked with Alice "on and off" over a number of years. Alice had recently returned to work on some issues related to depression. June felt competent to work with the depression issues Alice was presenting. However, during one particular session Alice "slipped into the conversation that she was sexually attracted to 12-year-old boys." June quickly identified this as a boundaries of competence concern. She said, "I immediately felt the alarm going off. Like OH, I don't want to deal with THIS. This is not what I deal with." June's identification of her boundaries of competence concern was clear and immediate.

Sally reported two situations in which she questioned her boundaries of competence. The first was a decision that needed to be made in the moment when she went to the waiting room to greet her client and discovered Gail had invited her mother to session. This confused Sally, as Gail had been working through some disturbing memories that involved her mother. It was immediately clear to Sally that she was encountering a situation for which she had not been trained; and she had to make a decision. She said, "at that point I was like, holy moly, . . . you know. She had all these terrible things to say about her mom. . .and she shows up with her." The second boundaries of competence concern involved an experiential technique Sally

wanted to use in Gail's treatment. She had some training but no supervised experience using this technique. Once she had presented this treatment option to Gail, she realized she might not be fully qualified to use the technique. She said, "I had taken a mini course in it but never the full course that leads to certification." In both situations Sally immediately realized her limitations and as soon as possible sought supervision to help her sort out her actions.

Five participants, Marti, Daniella, Susan, Jim, and Bill, reported wondering about their competence to treat during the process of treatment with their selected clients prior to being sure about their limits. Each reported coming to a specific point in treatment when they no longer wondered but were sure they were facing a boundaries of competence issue.

Marti had worked with Doris around depression and marital issues. She had presented for treatment initially for depression, finished her work, and about 6 months later returned for additional treatment. Marti had felt good about her ability to treat Doris for depression. However, when Doris returned to treatment the issues she presented caused Marti to wonder about her ability to treat these new issues. Doris wanted to have a baby. Marti described the situation, saying,

> She wanted to have a baby and [her husband] was unsure. He was mostly resisting [the idea], but [also] he was impotent most of the time. So, to her dismay, they didn't have very much of a sexual relationship. She was a very frustrated lady. . . and very sad.

According to Marti's report, Doris attended 2 or 3 more sessions after her initial return visit. At some point in these sessions Marti began to wonder if she could be of any more help to Doris. During the final session she reported realizing that she did not

have the training necessary to do the level of sexual counseling she believed Doris and her husband needed. She said, "I didn't see anything else that I could do for her." Marti wondered about her limits of practice for a short time. When she had clearly determined she was beyond her competence level, she almost immediately made a referral.

Daniella reported that, although she felt she was over her head with Lucy, she did not know, as a young clinician, that is was OK to say so. She said,

> I started feeling overwhelmed and wasn't sure if I was being an insecure therapist or if was I really overwhelmed. I didn't feel like anyone ever really talked a whole lot about that in school. [No one] said "it's OK to be not qualified for a certain situation. It's OK to refer out." At this point I wasn't aware of that. At this point it was like, "You're the best we've got. You've got to go out there. You got to make this work. So I felt like this was my responsibility. At this point I'm like: Am I just being insecure or am I really in over my head?"

It was not until after Lucy became physically violent in a session, was admitted to the hospital, and diagnosed by the hospital staff that Daniella was able to say she was over her head. In the interview she said,

> When I found out [the hospital diagnosis], then I knew, "I'm in over my head. I don't know what that is. I don't know what that is. I don't know why a kid would do that. At that time I knew nothing about psychotropics. I knew nothing about side effects."

When Daniella finally felt permission to say, "I'm over my head," she was very expressive about her newfound freedom to not know.

Susan had an inkling during her phone intake interview with George that he was dealing with more than career issues. After the first interview, she had no hard data to tell her that George had mental health concerns, which needed to be tended to before career counseling would be successful. She explained the next two sessions, saying,

> At the end of [the second session], the information still wasn't on the table, but I was very concerned by that time that this was going to be something way beyond what I do. I really only do career counseling. I do not get into any kind of therapeutic counseling unless it revolves around work and the workplace. To me it was something beyond that.
>
> He came for the third appointment. By that time I don't know if he was just tired of trying to run around the bushes or if there was enough trust. He shared with me that he had been in treatment for a [mental health] disorder.

At this point, after some wondering, Susan had the information she needed to state clearly that she was beyond her boundaries of competence.

Jim had worked comfortably as a co-therapist with Mary in a group setting and had worked confidently with sexual abuse issues with boys. However, when he was assigned to work with Mary in individual therapy, he became uncomfortable with some of the session material. Mary began to talk about her sexual abuse issues and expressed an attraction to him. Jim said he "felt pretty confident about doing [sexual abuse] counseling with little boys." However, when Mary expressed an attraction, he started to wonder if it might be counter-indicated for him, as a man, to be doing sexual abuse work with a girl who was attracted to him. He said this was "something totally different." The following excerpts from Jim's transcript describe his process of identifying Mary's attraction as an issue he did not feel competent to handle:

> I wasn't expecting for the client to have an attraction for me. I didn't know how to deal with that and I wasn't sure of what I should do. I thought about just letting the supervisor know and excusing myself from her case altogether when I first found out that she had an attraction for me. [Then I let it go and] I didn't think anything [more] about it.
>
> I [met with] her on two other occasions before I actually went to my supervisor about it. The reason being: I just thought it was a phase she was going through and I didn't think I would have a problem with it

> However, on the second time after I found out that she had the attraction for me, she asked me some specific questions, which I didn't feel comfortable with her asking me. So I went ahead on and finished that session and [later] I talked with my supervisor about the possibility of transferring the case to a female therapist.

Jim wondered about his competence to deal with Mary's attraction to him given her sexual abuse history. This wondering went on for several sessions before he finally identified it as an issue that was more than a passing phase. He came to recognize this as a boundaries of competency issue that he needed to address.

Bill selected Ray for his case presentation in the face-to-face interview. Ray and his family were members of Bill's congregation. Bill was treating Ray at the time of the interview. His work with Ray had included some therapeutic contact with Ray's wife, who was also a member of his congregation. Bill reported that early on in his work with Ray he had some concern about his ability to treat Ray. These concerns emerged from an understanding of his limited experience as a mental health counselor and the circumstances of his practice setting. Shortly before the face-to-face interview Ray's wife had requested a session during which she shared some information that was foundational to Bill's becoming clear about his competence issues related to treating Ray. Bill described his reaction to that session:

> [Ray's wife is] a strong, talented, thoughtful, and capable person. I know [because] I've experienced her as a good member of our church leadership team. To see her sitting there [feeling] just helplessness made me think, "this is real serious." [I was] thinking, "this is beyond me." If I had a clinic in here or if I had a psychiatrist down the hall, I'd say, OK. So part of my judgments are practical. I mean, I just don't have the supportive resources here. That's one of the reasons. Another part of my judgment is that even if I do have the supportive resources, there are many, many things that I do in my role as a pastor that mean I cannot be carrying . . . clients who are having serious problems. Also, I get a little bit frightened [in] the area of rage-full behavior and [serious] depression. I see this description by [Ray's] wife as a change in behavior that's really gone on for at

> least a year. I mean, this has really gone on for a long time. I'm not an expert in depression. I don't see depressed people all the time, so I have a hard time making the judgment in terms of the intensity of this depression.

Bill had wondered about the level of Ray's difficulties, and consequently, the appropriateness of his treating Ray prior to this session with Ray's wife. As he described his reaction to the information Ray's wife shared with him, Bill was clearly able to articulate the moment he understood his boundaries of competence issues in relation to Ray's mental health difficulties.

Sarah and Eva both reported a general questioning of their boundaries of competence with their selected client cases. Neither of them clearly identified a particular time in the treatment process that alerted them to their limits. In telling their stories both Sarah and Eva wove a general awareness of their boundaries of competence concerns throughout the process of reporting their ethical decision-making processes.

Sarah's boundaries of competence concerns with Carl started early on in the treatment process. As Sarah came to believe Carl was unable to work well with the techniques she was most trained to use in treatment, she began to wonder if another therapist would be a better fit for him. Sarah also believed that Carl was resistant to working on the core issues underlying his difficulties and wondered if she had the wherewithal to help him break through this resistance. The process Sarah described was one of wondering, questioning her limits with Carl, and trying a variety of modalities to address her concerns. She did not identify a point in time that told her she was clearly beyond her boundaries of competence.

Eva reported her initial encounter with her selected client, George, as being a phone intake interview. She described this phone intake by saying,

> [George] called seeking bereavement services within a week of [his wife's] death. During the initial intake phone call, he indicated he wanted tools to get through this bereavement and he [stated that he had] a history of depression and feared he would go into a black hole.

The agency Eva was working in focused on bereavement work and had a eight-session limit policy. Eva ended up working with George for the better part of a year and was aware for a good part of that time that he was dealing with issues beyond her agency mandate and her own practice limits. She explained at several points in the interview that her agency worked solely with bereavement and generally limited each client to six to eight sessions. Eva reported feeling very competent with grief counseling, but she felt her work with George extended beyond grief counseling. She regularly consulted with her supervisor about her work with George. Eva reported that she and her supervisor determined continued treatment was the right choice because of the complexity of the case. At no point in the interview did Eva state a specific moment when she knew she was beyond her boundaries of competence. What she did communicate was a persistent awareness that she needed to attend to her training and experience limits in light of George's overall presentation.

Bob and Beth, as experienced counselors, reported cases from their novice days that had been terminated years earlier. At the time of their cases they were both aware of dealing with situations for which they were lacking in training, knowledge, and experience. Neither of them was helped sufficiently by the supervision they had at the time of their reported experiences, but both of them had spent the intervening years

investing in activities that promoted professional growth. At the time of the interview both, in hindsight, were able to put words to the boundaries of competence concerns they encountered with their selected clients.

Bob knew he was uncomfortable with Jennifer's silence. During the interview he reflected on their sessions, saying,

> Usually I would talk the first 5 minutes, but the rest of the time we would sit there in silence, which at that time I wasn't very good at. I didn't understand the therapeutic process of [silence]. Basically, I thought I was just sitting there wasting my time. I went through probably 3-4 years of being very lost with this client, not knowing what to do. Still don't [completely understand] what I did with her. In a lot of ways I've been able to put some things together. [That's] hindsight but at the time it was very overwhelming ... wondering if I was doing more harm ... am I enabling her.

Bob sought supervision and ran into systemic confusion and mixed messages about his interventions with Jennifer. The supervision added to his sense of confusion and feeling of being lost. As Bob's story unfolded he was able to talk about his understanding of the dysfunctional system and negative supervision dynamics in which his work with Jennifer was embedded. As Bob was talking about the supervision he does as an experienced counselor and agency clinical director, he said, "sometimes silence is a good thing." This was said with a bit of a smile and seemed to be said as a statement of self-assurance and understanding of professional growth. Bob, as a young clinician, was clear about his sense of being lost in his work with Jennifer, but, at the time of the interview, he clearly articulated not only his novice experience of being beyond his competence with Jennifer's silence and her late-night calls filled with suicidal ideation. He was also very clear about feelings of being

confused by mixed messages in supervision and the dysfunctional system dynamics that surrounded his work with Jennifer.

Beth was clear, at the time of the interview, about her boundaries of competence issues in her work with Anne. Like Bob, Beth knew she was over her head while working with Anne. Her interview data seem to indicate that she could not have articulated her concerns as a novice counselor nearly as well as she did as an experienced counselor during the interview. With years of continued training and experience behind her, Beth was able to assess the situation more clearly. She wove her statements indicating her novice lack of understanding and her experienced counselor insights into the story of her work with Anne. She had worked with Anne and her significant other, Doug, for some time. DCFC had taken Anne's kids away. After some work with Beth, Anne got her kids back and stopped coming for counseling. Beth continued her story, saying,

> Things were going really well for her, and then [she and Doug] broke up. He walked out the door on her, which was devastating. What I didn't realize. . . I did not know that she had schizophrenia. All the time it was really being well controlled by medication. And then, when he left, we worked for a while trying to keep it together.
>
> I wasn't as sure then. I don't think I was good at handling her crisis.
>
> Right before they took the kids away, she'd returned to therapy and I could see that she was in really bad shape. She'd stopped taking her medicine . . . and I still didn't pick up what we were dealing with the schizophrenia. She didn't present as having hallucinations. [She was] a little delusional but then she was really good at holding it together for an hour.
>
> So in therapy I wasn't catching it. She ended up being kicked out of her home. DCFS got quite involved. They put her up in a hotel and eventually they found her high. So they took the kids away again, at which point then she threatened to kill both of her DCFS caseworkers and me.

> Looking back, I think I wasn't equipped. I didn't see it coming. I just didn't see the signs. I didn't recognize it. . . . I didn't know how to deal with someone threatening me. I knew what to do when she threatened other people.
>
> I didn't discern between the drugs and the mental illness. It didn't connect for me. It happened really fast. Looking back it seemed like [her disintegration] happened in a couple of weeks. She went that fast.

As Beth described her map and discussed the rounded rectangle content symbol labeled *My Shortcomings* to the left of center in the top row labeled of her map (Figure 15), she restated her boundaries of competence issues in working with Anne. She said, "*My shortcomings*: I wasn't equipped; I didn't know she had schizophrenia; didn't discern between the drugs and mental illness; my early neophyte skills."

Beth, like Bob, had sought supervision but had not found it of much help. At one point in the interview she referenced her early skills in combination with her reliance on Rogerian theory in combination with her understanding about its limits and consequently her limits at that time in her professional life:

> I think I [fell short in part because] my early skills relied on easier, shorter theories. . . . My supervisor was a very nice man, but I also think he was very much into client-centered [therapy]. It's not that Rogerian [theory and therapy are] easy, but client centered has its limits at some point when you're dealing with the chronically mentally ill, violent people. I think this was a turning point for me in beginning to understand how serious a business this is. That this really can be about life and death.

Time and experience had given Beth perspective about her work with Anne. Her statements about what she had not understood with Anne were presented as honest and insightful assessments of her boundaries of competence concerns. As an experienced counselor Beth was able to articulate her clear understanding of the limits she had as a novice counselor working with Anne.

Sam never specifically identified a point in time when he knew he was over his head, nor did he clearly articulate the concerns that were beyond his competency. During the intake process Sam was given some indication that Deb was a challenging client. Throughout the interview Sam reported having a vague awareness of something being amiss in his handling of Deb's statements about Joe. It was at the end of the interview that Sam came the closest to identifying his lack of training and/or experience in dealing with the situation he had encountered with Deb. When asked about how his training in ethics had prepared him, he said, "I knew not to get involved with a client, but when it came to a client discussing another therapist, I was thrown for a loop." Sam's awareness of the boundaries of competence issues he was facing with his selected client seemed to be a muddle of client statements, agency policy regarding such statements, supervision/administration mixed communications, and Sam's own internal conflict.

All of the participant maps are about identification and/or awareness of boundaries of competence issues, but only five maps contain content symbols that overtly label awareness of limits and/or the issue(s) in question. Marti's map (Figure 4) contains one content symbol located at the right-hand side of her map and labeled *Practical: Referral when unable to take client any further into insight,* which houses both her boundaries of competence awareness and her action for resolutions. Matthew and Jim created content symbols labels that identified their particular concerns. Matthew's map (Figure 6) contains two symbols identifying his specific concerns. Within the *Presenting Information* long, rounded content symbol at the right of his

map Matthew places two subheadings that specify his concerns. One is *Medical Disorder and* the other is *Psych. Meds.* The small circle at the center of the map labeled *Age,* by its placement on the map and its label, demonstrates the significance of Matthew's concern about the age difference between his client and him. Jim's map (Figure 13) contains a rounded rectangle towards the top of the map labeled *Affections for Therapist.* The flow lines indicate that this was the first item after the initial intake sessions, and thus, offers some insight into the importance this concern held in the therapeutic and ethical decision-making processes. Suzy and June both created content symbol labels, which revealed there was an issue of concern. Daniella's map (Figure 8) reveals something of the process of becoming aware of her boundaries of competence. The map flows from top to bottom and in the second row is a large rounded rectangle labeled *Symptoms: Is this my insecurity or was I not qualified for this.* Just below this content symbol is another smaller rounded rectangle labeled *Hospital Information: Now I am sure I'm not qualified.*

Participant maps do not contain an abundance of content symbols that overtly reveal the timing of awareness and/or identification of their boundaries of competence concerns. However, participant discussion of the maps did yield a significant amount of data about how awareness of their boundaries of competence concerns was woven throughout the ethical decision-making process. These data are reported in detail within the map descriptions of other categories.

The common characteristic of this sub-sub-sub-category is that all participants selected client cases in which they encountered boundaries of competence issues.

Participants reported coming to awareness of their boundaries of competence under a wide range of circumstance and at varying times in the designated therapeutic relationships. The identified boundaries of competence concerns included a wide range of client issues and/or clinical concerns. Five participants were alerted to their competence concerns at a specific point in the time. Three participants reported a gradual sense of concern that ended at a specific point in time with a clear understanding that they were beyond their limits of competence. Two participants, who were novice counselors, reported a general sense of unsettledness about their competence and their client concerns over the duration of their decision-making process. Two participants, who were experienced counselors at the time of the interview but novice counselors at the time of their work with selected clients, articulated the timing and nature of their concerns with insights gleaned in the intervening years of learning and experience.

All but one of the participants clearly articulated the nature of their competence concerns. One participant seemed confused about the circumstances of his selected client case. His interview occurred a couple of years after the case was terminated and although knew he had been over his head, his understanding of the nature of his concerns was rather a muddle.

Response to concerns sub-sub-sub-category. Participants described the various responses, strategies, actions, and rationales they developed and/or implemented in response to their boundaries of competence concern(s). This sub-sub-sub-category references data related to counselor strategies and actions from the point of awareness

through the resolution. Participant responses to boundaries of competence concerns included utilizing literature, seeking clinical guidance, considering and/or working out of the therapeutic alliance, considering the client and applying moral principles, working with the client to reach resolution, interacting with the system(s) in which the client case was embedded, and selection of and implementation of an action plan that would lead to resolution. A significant portion of the data related to counselor responses to boundaries of competence concerns formed the supervision dynamics, system dynamics, and outcome categories. Data reported in these separate categories will be briefly reviewed and the reader will be referred to corresponding categories for an expanded discussion of the data.

Participant responses which are unique to the therapeutic relationship category and reported in this sub-sub-sub-category are limited to interactive dynamics between counselor and client. These responses include dynamics of the therapeutic alliance, counselor regard for client or demonstrating moral principles, and/or working with the client on outcome options. The three doted lines shown in Figure 17 labeled *Working Alliance, Counselor Regard for Client,* and *Working with the Client* represent the international dynamics that were part of participant-reported ethical decision-making processes.

The discussion of counselor responses to their boundaries of competence concerns begins with data that are presented elsewhere in this chapter and ends with presentation of data unique to this sub-sub-sub-category. Participant utilization of the literature begins the discussion. A brief review of participant actions to seek clinical

guidance is the second counselor response to boundaries of competence concerns reviewed in this sub-sub-sub-category. This followed by an overview of participant selection and/or implementation of a plan for resolution. Data related to the impact of system dynamics on participant decision-making processes is presented next. Discussion of the three areas which are unique to this sub-sub-sub-category begins with data related to the working alliance, continues with participant regard for clients, and concludes with participant description of how they worked with clients to reach resolution.

Reviewing or researching literature was a resource used by three of the participants. Matthew did Internet research as an active response to his boundaries of competence concerns with Franklin. Eva referred back to material on adult children, co-dependence, depression, and grief as part of her attempt to resolve her competence concerns. Sam referred to journal articles in his aftermath/post-outcome reflection process in an attempt to understand what he "should have done" differently. Matthew, Eva, and Sam's utilization of literature has already been discussed in the counselor as a professional sub-sub-category within this therapeutic relationship category and therefore, is only being noted here. Utilization of professional literature as a professional resource for ethical decision-making is detailed in the counselor as a professional sub-sub-category within this therapeutic relationship.

Seeking clinical guidance was a response used to resolve boundaries of competence concerns by participants. Participants reported seeking clinical guidance through formal individual and/or group supervision as well as through peer

networking. Thirteen participants reported seeking some type of clinical guidance during their ethical decision-making process with selected clients. The significance of supervision in participant ethical decision-making processes is symbolized in the numerous content symbols and flow lines within participant maps highlighting supervision. These content symbols and flow lines underscore the influence and impact supervision had on participant decision-making processes. Some of the supervision was reported as positive, some as neutral, and some as negative. These content symbols are briefly highlighted at the end of this sub-sub-sub-category in the participant map section. The reader is referred to the supervision dynamics category for a more detailed discussion of reported clinical guidance experiences.

All participant responses to their boundaries of competence concerns included selection and/or implementation of a plan for resolution. Both selection and implementation of actions varied significantly from participant to participant. Continued treatment and termination were the two reported resolution options. Four participants made decisions to continue treatment. Ten participants selected to work toward termination by finding and presenting referral options. Five of the ten who selected termination experienced a *counselor-directed termination.* In this study a counselor-directed termination is defined as a termination event or process in which the counselor (a) initiated an intervention suggesting referral and (b) directed and implemented the termination event and/or process. The remaining three participants who reported termination as resolution described *client-determined outcomes.* In this study a client-determined outcome is one in which the client ultimately controlled the

outcome by not returning to treatment and thus initiating termination. Two participants, who had not initiated any conversation about referral or termination, reported client-directed terminations. Three participants reported clinical situations in which resolution was significantly intertwined with system dynamics. Details about the processes leading to resolution, selection of resolution actions, and implementation of resolution are presented in the outcome category.

System dynamics are part of this sub-sub-sub-category because several participants reported that their responses to boundaries of competency concerns, development of treatment strategies, and implementation of interventions were impacted and/or directed by system dynamics. A system is defined in this study as a mental health agency with stated policies affecting clients they serve and counselors who work with these clients. System dynamics are defined in this study as the interactions between mental health agencies which have the inherent power to impact therapeutic relationships, treatment plans, ethical decisions, and clinical outcomes. Three participants reported system dynamics as directly impacting their responses to boundaries of competence concerns in a negative way. Six participants reported either positive or neutral system dynamics. The remaining five participants selected client cases that were not embedded in or influenced by agency or institutional systems. Details about the influence and/or impact of system dynamics on participant responses to boundaries of competence concerns are reported in the system dynamics category.

Developing, considering, and/or working out of the strength of the therapeutic relationship or working alliance were parts of participant-reported process of ethical

decision making. The therapeutic relationship was defined earlier in this category as the bond between client and counselor, which was formed to accomplish specific tasks and goals related to helping the client resolve concerns. A working alliance is an essential part of the therapeutic relationship. According to Egan (1998) the therapeutic or helping relationship is collaborative. Egan further pointed out that "Helping is a two-person *team* effort in which helpers need to do their part and clients theirs. If either party refuses to play or plays incompetently, then the enterprise can fail" (p. 41). Participants demonstrated that the working alliance impacted the decision-making process.

Only three participants, Daniella, June and Bill, directly or formally referred to the therapeutic relationship, bond, or alliance as part of their ethical decision-making processes. When Daniella was asked about what, if anything, she saw in her conceptual map about how she proceeds through ethical decision, one of the things she noted was the therapeutic relationship. She said, "Mostly what stands out for me is just the building of relationship. Before I focus on anything [else], that is what I work on no matter how long it takes." June referred to her longstanding relationship with Alice and, in her process of deciding to continue treatment, cited their therapeutic alliance as one of the key reasons. She said, "[Alice] has trust issues and over the years we have formed a therapeutic alliance." At another point in the interview June again referred to her consideration of the relationship as part of her decision-making process, saying, "we've worked together for quite a long time and I know she trusts me so I'd be concerned [about how that would] interfere [with her work]." When Bill was

describing his map he referred to the therapeutic "bond" as a part of his decision-making process. He pointed to one section of his map and said, "You begin to bond with the client. The bonding is here." Direct mention of the therapeutic relationship as a part of their decision-making processes was a characteristic common to Daniella, June and Bill.

For Sarah, Matthew, Susan, and Eva the lack of a working alliance was central to selection and implementation of actions in response to boundaries of competence concerns with their selected clients. Sarah wondered if Carl was really working or if he was capable of using the modalities she was trained to use. She indicated there was a therapeutic relationship but struggled with whether or not she and Carl were really working together at a significant enough level to justify her continuing treatment. Matthew did report that he and Franklin were able to work through an upset Franklin had with his approach to their relationship, but his overall conclusion was that Franklin really didn't want to work at change. Therefore there really wasn't an alliance out of which they could work. Susan believed George was not able to engage in career work until he dealt with his mental health issues. George did not want to deal with his mental health issues and the result was that there were no mutually agreed-upon tasks and goals. Eva described Ed as resistant and at no point did she indicate there was a working alliance in their relationship. Sarah, Matthew, Susan, and Eva shared the common characteristic of selecting clients with whom they did not have a working alliance. In each of these cases, the outcome was a client-determined

termination. Perhaps this is illustrative of the failed enterprise Egan (1998) pointed out would occur if both parties were not engaged in the team effort.

Regard for client circumstances was an integral part of participant selection and implementation of actions in response to their concerns. Participants reported giving consideration to clients' circumstances, needs, and wants in developing, selecting, and implementing actions relative to boundaries of competence concerns. The six moral principles generally listed in the literature for guidance in ethical decision making provide a framework for conceptualizing the regard of clients, which participants demonstrated and/or reported in process of responding to their concerns. These five moral principles are autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity. Discussion of participant regard for clients is ordered around these moral principles. It should be noted that if a given participant is not mentioned in connection with a given principle, it is because the participant did not provide data related to the specific principle.

None of the participants used any of the formal names for the principles; but there was reference to the concepts contained within the principles of autonomy, nonmaleficence, beneficence, and fidelity. The principle of justice or the fair treatment of all individuals has some overlap with the virtue ethic of respectfulness. Data related to justice has been sufficiently covered in the discussion on virtue ethics and will not be repeated her. Veracity sets the truthfulness portion of fidelity apart from loyalty and commitment, and, according to Corey et al. (2003), includes efforts to "insure that clients understand the implications of diagnosis, the intended use of tests and reports,

fee, and billing arrangements" (p. 17). None of the participants referenced these matters and therefore no data emerged relevant to veracity. This discussion will focus on participant consideration of client circumstances and concerns, which emerged from the data related only to autonomy, nonmaleficence, beneficence, and fidelity.

Autonomy is about respecting the individual including his or her choices, freedom, and dignity. Respect for client autonomy is revealed in the approach participants took in describing client background material. Participant regard for client dignity is embedded in data presented in the client background sub-sub-category. In addition, the general sense that participants respected client autonomy seen in the client background, Sarah, Marti, and Sally made statements that demonstrate awareness of the issue of client autonomy.

After Sarah had described her map, she was asked what it revealed to her about her own process in resolving her concerns with Carl. During her response to this inquiry, Sarah seemed to struggle with client autonomy versus counselor responsibility. She said,

> It's always a learning and growing process with every client. I'm always adding skills starting with a modality, checking back to see [if it is] touching what needs to be touched, and adjusting if I need to adjust. If the client is saying that they're making progress, they know that best, but I also have ideas about what they need to be doing.

Sarah acknowledged Carl's autonomy in her ethical decision-making process, but did not feel Carl's report of progress could be the final and/or only measure of her competence.

Marti presented some suggestions to Doris about how to handle her situation. Marti seemed to acknowledge Doris' freedom of choice and autonomy in deciding what to do with the suggestions. After Marti described the options she saw as potential solutions for Marti's concerns, she said, "She understood . . . and so she decided she would do that." This statement is consistent with the attitude Marti presented throughout the interview. She seemed to have an objective view of the realistic options Doris had to work with and a perspective that Doris was her own person who was free to select whichever option worked for her.

Sally invited Gail to participate in an experimental exercise. However, she questioned her competence in using the suggested techniques. Sally said, "I wanted to do [this technique] with her and she was afraid." Gail decided against participating in the exercise and Sally said, "Of course I honored [her choice]." Although Sally had invested a great deal of energy to resolve her competence concerns around using the specified technique, she quickly honored Gail's choice to decline the intervention.

The common characteristic for Sarah, Marti, and Sally is their awareness of client autonomy. Sarah struggled with how to balance client autonomy and professional responsibility to understand limits. Marti and Sally reported situations in which they clearly and quickly offered their clients freedom to select treatment options.

The data related to nonmaleficence and beneficence will be coupled together. Nonmaleficence is the principle commonly known as "above all do no harm." Beneficence refers to the "do good" principle. One could conclude that by virtue of

each of these 14 participants volunteering for this study, each has affirmed her or his struggle to both do good and not to cause harm. Two participants, Bob and Suzy, specifically mentioned their concern about not doing harm in their interviews. Bob reflected on his work with Jennifer and said, "At the time it was very overwhelming and I wondered if I was doing more harm [than good]." At one point in the interview Suzy was reviewing her boundaries of competence concerns and declared, "I know I'm not going to touch anything that I would be hurting someone. I'm not. I wasn't going to touch this with a ten-foot pole." Later Suzy said, "So it tells you that's how you do therapy. I care about people. I don't want to hurt anyone. It would stink if I did." Although only two participants made direct statements about their awareness of the professional concept of "do no harm," it is clear that all 14 participants who volunteered for this study had an interest in doing good and not doing harm.

The final item of consideration in this sub-sub-sub-category dealing with counselor responses to boundary of competence concerns is how participants described working with clients to reach resolution. Three participants, Sarah, Susan, and Eva, attempted to work with clients around their concerns, but reported clients would not work with them on these concerns and/or they took control and implemented termination on their own terms. Four participants, Marti, Matthew, June, and Bill, did not work with selected clients around boundaries of competence concerns. Three participants, Suzy, Daniella, and Sally, reported mutuality in working with selected clients at some point in the decision-making process around boundaries of competence concerns. Four participants, Bob, Sam, Jim, and Beth were in situations

in which the system influenced and/or directed participant actions, selection of resolution, and/or implementation of resolution so that there was little or no opportunity to work with clients around some aspects of the reported concerns. However, Sam did indicate that he could have done more to work with Deb to get to a different resolution.

Three participants, Sarah, Susan, and Eva, each attempted to work with their clients around their boundaries of competence concerns. Sarah's attempt to work with Carl on reaching a resolution was to suggest the possibility of a referral for some of his work. However, after Sarah approached Carl with her concerns and made a referral suggestion, Carl never returned for treatment. Susan approached George a number of times about her concerns and suggested referral, but George was not interested. In the end George terminated but refused referral. Eva told Ed many times that she believed he needed to move into a different therapeutic setting. Ed was resistant to these suggestions but in the end terminated treatment with Eva. Sarah, Susan, and Eva approached their clients about their boundaries of competence concerns. Each of them reported client-directed terminations following one or more attempts to work with their selected clients to reach a mutual resolution for the concerns around practice limits.

Marti, Matthew, June, and Bill responded to their boundaries of competence concerns in a variety of ways, but each took a counselor-directed approach to determining, planning, and implementing resolution for their concerns. Marti decided on her own plan for referral and termination and implemented the plan as a counselor-

directed intervention. Matthew never reported talking to Franklin about his boundaries of competence concerns. June and Bill decided on continued treatment as their own outcome plans. June did not plan to share her concerns with Alice. When asked if Alice knew of her concern, June said, "No. No. I know that it is said out there that you need to be honest about [such things], but I've found that sometimes you don't have to be totally honest. If she knew about my dilemma, she would not be able to talk [and do her work]." Bill intended to share his concerns only if, after he had implemented his plan, he still felt he was beyond his practice limits. Marti, June, and Bill share the common characteristic of counselor-directed resolution and implementation. They did not work with their selected clients around their boundaries of competence concerns.

Three participants, Suzy, Daniella, and Sally reported working with their selected clients concerning boundaries of competence issues. Suzy approached Patrick with her concerns and discovered he had another therapist working with him around these issues. Daniella, after making an intervention for emergency hospitalization, worked with Lucy and her parents on the transition to long-term residential care. Sally invited Gail to participate in an exercise involving an experiential technique. Although Sally did not share her concerns about using the technique with Gail, she did work with her client in the decision to use or not use the technique and gave Gail the final say in determining not to use the technique. Suzy, Daniella, and Sally all share the common characteristic of working with their selected clients to reach and/or implement resolution for their boundaries of competence concerns. There is a sense of mutuality between counselor and client in their decision-making processes.

Eleven of the 14 participant maps highlight their responses to boundary of competence concerns. Responses highlighted on maps include seeking supervision, action planning, and implementation of resolution. This sub-sub-sub-category, counselor approach to treatment and response to boundaries of competence concerns, addresses the question: How did the participants approach the therapeutic and ethical decision-making processes? The flow of each participant's response to his or her boundaries of competence concern, including selections of actions and implementation of actions, is presented in detail in each individual profile and had consequently not been restated in this sub-sub-sub-category. However, because participant maps generally present an overview of participant responses to their boundaries of competence concerns, the maps have been used here as an overview of participant responses to boundaries of competence concerns. Participant maps are covered in more detail here than is typical in other sub, sub-sub, and/or sub-sub-sub-categories.

Sarah (Figure 3) created a map she said she saw as "a spiral." The spiral is basically a representation of the various actions she created and implemented to find resolution for her concerns. Four of the content symbols Sarah created showcase her actions. The first is the long, rounded rectangle in the center of the map labeled *Back to Issues (0)*, and is the point into and/or out of which all the other content symbols flow. The second is the circle on the right-hand side labeled *Work with standard Modality (2)*. The third is the oval on the left-hand side labeled *I learn more/Some Progress (3)*. The fourth is the rounded rectangle at the upper right of the map labeled *Used different Modalities to try to go to core issue, more resistance (4)*. Each of these

content symbols represent Sarah's actions plans for resolution of her boundaries of competence concern.

Bob's map (Figure 5) contains one content symbol and a grouping of flow lines, which represent his action to seek help from his supervisor to develop a plan for resolution. The rounded square just to the left of center at the top of Bob's map labeled *Supervision/2 supervisors working at cross purposes* contains the data relevant to his numerous attempts to seek guidance. The double-pointed flow lines identified by the words *No Answers/No help* link the *Supervision* content symbol to the content symbol labeled *Feeling Lost* to emphasize the unsuccessful nature of the supervision Bob described in his interview.

Matthew's map (Figure 6) contains four content symbols and two flow lines, which reference actions he took to reach resolution of his concerns. The first two are on the right-hand side of the map and connected by double-arrow point flow lines. The small rectangle just above and to the left of center on the map labeled *Thought About where to Start* is the beginning of his planning and linked by flow lines to his concerns and initial actions. The large rounded rectangle content symbol at the left of the map with the primary label *Presenting Information* contains three Post-it® notes reading, *Thinking I need to get Info., Internet search, looked at medication in PDR*[1]. All of these notes address planning or implementing action leading toward resolution of concern. Matthew reported using supervision as a primary action to reach

[1] PDR is a reference to the text *Physician's Desk Reference,* which is published and updated regularly by Thompson, and used by the mental health profession to understand prescription drugs.

resolution for his concerns and used the content symbol circle located towards the upper right of his map labeled *Knowledge & Experience* as his supervision symbol. He placed all of his Post-it® notes referencing supervision in this symbol. The final symbol referencing actions is the rounded rectangle within another rounded rectangle in the bottom right corner of the map labeled *Goals, Tools, Interventions.* Matthew placed Post-it® notes in this content symbol that outlined his actions with Franklin and his use of basic skill in implementing his interventions.

Suzy's map (Figure 7) contains three content symbols detailing her actions subsequent to her resolution to continue treatment. The first is a rounded rectangle in the center of the map labeled *Comfortable with continued treatment due to specialist* and contains Post-it® notes referencing Patrick's relationship with the second therapist who worked with the material that caused Suzy to declare her competence limits. The content symbol above this one is a rounded rectangle labeled *Progress of continued treatment* containing three Post-it® notes. Two of the Post-it® notes reference actions Suzy took to insure resolution to her competence concerns. The notes read *Work as a team* and *talk about [Patrick] in supervision mostly every week.*

Daniella's map (Figure 8) contains three content symbols addressing the actions she took to resolve her concerns. The first is a rectangle at the left of the map labeled *Called Supervisor* referencing her initial action. The second is a rounded rectangle labeled *Following Procedures of Work* containing three Post-it® notes referencing Daniella's actions that followed her supervisor's instructions. The third is a long, thin rounded rectangle in the row second from the bottom and labeled *Termination with*

Client delineating the termination process with Lucy and her parents under her supervisor's guidance.

Sam's map (Figure 9) tells the story of his confusion and conflict in the process of acting to resolve his concerns. There are two content symbols in Sam's map that are relevant to action but refer primarily to his post-outcome reflections about actions he might have taken. The first of these symbols is the bottom circle in the row of circles at the left hand-side of the map labeled *What I should have done.* The second is the circle at the bottom center of the map labeled *What I did as a therapist/What I thought was ethical.* As Sam was labeling and describing these symbols, he said,

> My training and experiences [influenced what I] thought I was suppose to do. I was taught [that] when a client tells you not to talk about something, you don't. It's their right not to pass on information. It's a privacy between you [and them]. I could have maybe processed more or gotten more information about it and helped her deal with this.

These symbols taken together and coupled with his statement seem to reflect his continued confusion about just how to respond to Deb's information and how to select or implement a plan of action.

There are two more content symbols and two flow lines on Sam's map representing the action or response part of his process. The smaller oval towards the top right corner labeled *Offending Social Service Provider* contains Post-it® notes telling the story of his interactions with Joe, the offending social service provider, and with Joe's supervisor. The large circle in the bottom right corner labeled *What transpired with services, the staff, and myself* reference the actions the agency took in directing Sam to terminate his work with Deb as well as the interventions made by the

state to determine culpability. These were actions that were part of the decision-making process, but they were not initiated by Sam. They did, however, require actions from Sam in terminating and clarifying his work with Deb. Sam highlighted system actions and impact with the words *System Dynamics* he wrote in the space between the two unidirectional flow lines linking the content symbol *What transpire with services, the staff, and myself* to *Things of Sexual Nature* and *Offending Social Service Provider content symbols.*

Susan's map (Figure 11) contains one content symbol and flow lines which address her efforts to resolve her concerns with George. The large circular content symbol at the top of the map labeled *What Happened* contains numerous Post-it® notes delineating her interventions and rationale for suggesting referral and continuing treatment. The flow lines show the order and pattern of these interventions.

Sally's map (Figure 12) contains two symbols containing Post-it® notes referencing her actions that addressed her concerns. Both of these content symbols are located within a larger content symbol located in the lower right corner labeled *My Thoughts and Efforts.* The first is a rounded square labeled *Efforts with client* located in the lower right corner of the *Thoughts and Efforts* content symbol. The second is a circle labeled *With Supervisors* located in the upper left corner *Thoughts and Efforts* content symbol. This content symbol contains Post-it® notes detailing Sally's actions seeking guidance to assist with the resolution of her concerns.

Jim's map (Figure 13) contains five content symbols referencing his actions to resolve his concern. Four of these five symbols reference supervision. The work Jim

did with Mary was embedded in an agency that required approval from his supervisor to make a referral, and referral was the action Jim believed was the right resolution for his concerns. His initial thought was written on a Post-it® note located between the content symbols labeled *Affection for Therapist* and *Talked to Supervisor.* This Post-it® note reads *Thoughts about reporting to supervisor and excusing self from case.* When Jim actually approached his supervisor with his concerns, she did not concur with his solution. Jim's persistence is shown in the next four content symbols. Jim has shown the flow or direction of his persistence with unidirectional flow lines. The content symbols, in order of occurrence, are all rounded rectangles and labeled *Talked to Supervisor, Supervision, Application of Supervision,* and *Lost/Transfer.* The long thin rounded rectangle labeled simply *Supervision* contains a number of Post-it® notes outlining the suggestions Jim was given by his supervisor. After applying these suggestions, Jim returned to his supervisor with another request to transfer Mary to a female counselor. He was again met with suggestions and continued to meet with Mary. The short, thin, rounded rectangle content symbol labeled *Lost/Transfer* tells the story of his feeling lost for that month, and gaining his supervisor's approval to make the requested transfer. The final content symbol, which references Jim's plan and actions for resolution to his dilemma, is a rounded rectangle located near the bottom of his map labeled *Finish up: Job done.* This content symbol contains the Post-it® notes delineating Jim's actions during the referral/termination session with Mary.

Eva's map (Figure 14) contains one content symbol and one flow line referencing her actions to resolve her concerns with Ed. The content symbol labeled *Supervision* located in the bottom right corner of Eva's map refers to her actions to seek constant supervision during her work with Ed. The flow line that encircles the map is also about the supervision. She referred to this as *Empowered Supervision.*

Bill described his map (Figure 16) as a bowl, and in this bowl he created pie-shaped pieces. Although Bill came to his plan for resolution as he was reviewing his map, he had been aware of his limits prior to the interview and had done some planning and implemented some actions. Bill created a map that for him was a bowl representing the ever-deepening relationship between himself and his client. One pie-shaped piece in Bill's bowl represents the bond he formed with his client and another is about creating treatment plans, seeking supervision, revising plans, and implementing plans.

The common characteristic in the responses to concerns: strategies and interventions sub-sub-sub-category is that all participants reported action subsequent to the emergence of their boundaries of competence concern. Some of the reported actions were participant-created and participant-initiated actions. Several participants, Bob, Sam, and Beth reported actions that were created, directed, and or implemented by systems in which selected client cases were embedded. Actions included seeking supervision, using literature as a resource, creating an alternative, and working with clients towards resolution of reported concerns. Giving consideration to moral principles, the therapeutic relationship, and client circumstances were also part of

planning and implementing actions. The actions led to a variety of resolutions, including continuing treatment, counselor-directed termination, client-directed termination, and system-influenced or system-directed termination. In several cases the system in which the case was embedded influenced or dictated action creation and implementation.

With the exception of Marti, June, and Beth, participants created maps that highlight their responses to reported boundaries of competence concerns. Sarah, Marti, Daniella, and Jim's maps contain content symbols that overtly reference their decision for resolution as making a referral or suggesting referral as a possible option. Suzy's map contains a content symbol that visibly points to her decision to continue treatment.

Overall ethical decision-making style sub-sub-sub-category. Participant response to boundaries of competence concerns that emerged with their selected clients gives a glimpse into each participant's ethical decision-making style. To say that each participant moves though all ethical decisions or even all ethical decisions related to boundaries of competence concerns with the same or even similar patterns as they did with selected clients may be stretching the data beyond appropriate generalizability. However, participants provided a rich look at the style 14 professional counselors used to resolve their boundaries of competence concerns with selected clients. The cases were embedded in various practice settings, and participants encountered a wide range of ethical concerns related to boundaries of competence issues. Each worked with the material presented to them in the particular context of the specific case, and reached

resolution by counselor determination, client determination, and/or impact of system dynamics. For nine of the participants resolution was a result of their intentionally selected and implemented actions. Resolution for one of those nine participants' resolution could be seen as an informed stumbling upon an agreeable solution. For five of the participants the resolution was reported as client-directed. Three participants reported systemic dynamics as an influential part of resolution. Outcome data are more thoroughly reported in the outcome category.

The overall style of decision making for participants in this study can be seen in their conceptual maps and generally could be described as non-linear and/or relational. Because participant conceptual maps provide an overview of ethical decision-making style, discussion of participant decision-making style and their corresponding conceptual maps will be woven together. Sarah (Figure 3), Bob (Figure 5), Matthew (Figure 6), June (Figure 10), Susan (Figure 11), Sally (Figure 12), and Eva (Figure 14) created maps with double-arrow-point flow lines, representing the non-linear and interactive nature of their decision-making processes. Daniella (Figure 8) created a map which contains one double-arrow-point flow line, but otherwise appears to represent a relatively linear process. Suzy (Figure 7) and Jim (Figure 13) created maps that contain only single-arrow-point flow lines, which appear to connect content symbols in a step-by-step linear fashion. Marti (Figure 4), Sam (Figure 3), Beth (Figure 15), and Bill (Figure 16) created maps that do not appear to overtly represent either a linear or non-linear decision-making process. Only seven maps appear non-linear and/or interactive without accompanying data from participant transcripts, but

when maps are coupled with transcript data, all but one of the participants, Jim, spoke of their processes as interactive and non-linear.

The maps created by Suzy, Susan, and Sally represent their decision-making style processes that were further illuminated by transcripts content. Susan and Sally created maps that appear to be non-linear and interactive. Sally took just a moment to study her map and said, "Well, I think, I mean, it's all interwoven together. So if I had to do arrows, I'd probably do arrows from every part – back and forward to each other." After she said this she went ahead and added many single-arrow and double-arrow-flow lines. Suzy created a map that appears, at first glance, to be linear; but her transcript content indicates it was a non-linear process of decision making. As Suzy finished her map she reflected on its general artistic appearance with some disappointment, saying,

> This isn't [how I thought it would look]. I thought it was going to be like a rainbow but it didn't come out that way. I'm really at a place with him where I feel comfortable working with him. It's a journey. It really does feel like a journey that we're going through.

Later, as she was trying to form clusters to make content symbols, she talked about her desire to find a way to show the interactive nature of her process with Patrick. When describing her map Susan said, "it's a very interactive process." Suzy, Susan, and Sally provided clear verbal data explaining and illuminating the non-linear interactive nature of their decision-making processes.

Daniella's map looks linear at first glance but transcript data reveals a non-linear process. The content symbol labeled *Symptoms: Is this my insecurity or was I not qualified for this* contains Danielle's back-and-forth process of trying to discern if she

was dealing with a boundaries of competence issue. The double-arrow-point linking the content symbols labeled *Hospital Information: Now I am Sure I'm not qualified* and *Importance of Supervision* represent her interactive process with her supervisor and struggle with her competence. The single-point-arrows leading from the content symbols *Symptoms: Is this my insecurity or was I not qualified for this* and *Termination with Client* to the content symbol labeled *Called Supervisor* also represent the interactive process that took place as she came to terms with her limits, sought direction, and tried to understand how to proceed. Although, at first glance, Daniella's map appears to represent a linear process, her decision-making process was infused with interactive elements related to clarifying her boundaries of competence, interacting with her supervisor around diagnosis, and protocol.

Although Marti, Sam, Beth, and Bill created maps that do not seem to reflect a linear or non-linear style of decision making, their transcript data support a conclusion that each used an interactive and non-linear process to work through their ethical dilemma. Marti reported a gradual process of coming to her resolution to refer Doris. She described a number of sessions and interventions that went between considering treatment options and referral recourses. Sam's decision-making style in the case he selected for his CMT might be best described as confused and conflicted wandering back and forth between client, supervisors, and system dynamics. His was not a linear process. Beth's map is a picture of client and counselor internal and external dynamics. Although the map does not illustrate Beth's decision-making style as linear or non-linear, her transcript is filled with observations about Anne's circumstances,

interactions with various individuals involved in the situation, and actions that were continually interactive and form a verbal web of decision-making struggle. Bill described his map as a bowl that is not linear but circular with back-and-forth movement. He said,

> What I've done [is] picture [the process] as a sort of a circle. It starts out with the outer edge of the circle [which are] for me the opening salvos. As an increasing trust in the relationship develops, I see it as getting [closer] to the issues the person really wants to talk about.
>
> And then as we move [inward], [there are] layers. And so we finally get into the core [issues]. It doesn't go that smoothly. I mean it has a kind of a movement. There are themes that replay themselves as you move [in and out].
>
> You could, also conceive this map as sort of a bowl. It is not just a flat piece of paper.

Marti, Sam, Beth, and Bill all described processes that were non-linear.

Jim's map is linear and his transcript reflects a linear process. His map moves chronologically from top to bottom in a step-by-step linear process. When Jim was asked to reflect on what he saw in his map, he said, "[I see a] chain of events happening in a specific type of order with one event leading to another." He was then asked if this told him anything about how he goes about making clinical decisions with difficult clients. He said,

> Methodical. If I'm stuck, I don't mind asking for help. It looks like it's all linear but it may not happen that [simply]. There may be some other things in there such as other steps, but for some other reason, I just don't remember or they don't really matter.

There is a hint of his discomfort with the linear nature of his map but he quickly added some information that seems to indicate that he is by nature a person who sees problem solving as a step-by-step linear process. In his reflecting he commented,

> If I get a sense that something is wrong, I think I first try to figure out exactly out what's wrong. I look at the problem and identify the problem. If I can identify the problem then more than likely, I can come up with a solution. But if I can't identify the problem then it's time to get another opinion.

Jim is the one participant who described a linear ethical decision-making style.

Although all 14 participants demonstrated a unique path in responding to their boundaries of competence concerns, all but one of the participants shared the common characteristic of an interactive and non-linear style of ethical decision making. The one participant who demonstrated a linear style was Jim.

Supervision Dynamics Category

The importance of supervision in the ethical decision-making process emerged early in the interviewing process as participants spoke of the impact supervision had on the course of decision making, clients, outcome, and their own sense of professional self. During phase four of each interview the researcher had freedom to inquire concerning emerging and/or incomplete issues presented in phases two and three. Because the importance of supervision emerged early in the interviewing process, the researcher frequently used a portion of phase four of the interview to explore supervision dynamics within selected client case scenarios.

The supervision dynamics category includes discussion of data related to participant clinical guidance experiences during the course of working with selected client cases. The supervision dynamics category presents data related to formal individual supervision and consultation, supervisor-led supervision groups, peer groups, and networking. The supervision dynamics category and sub-categories are

diagramed in Figure 18, which illustrates four types of supervision experiences as reported by participants. Key concepts that emerged in the data regarding supervision experiences include affirmation, empowerment, support, professional growth, meticulous oversight, challenge, instruction, imprecise, blurry, dim, faint, vague, chaos, disruption, confusion, contradictions, and impact of unhealthy systems. These concepts are descriptors of the positive, indistinct, and negative clinical guidance sub-categories and are listed as key words within in the corresponding content symbols in Figure 18.

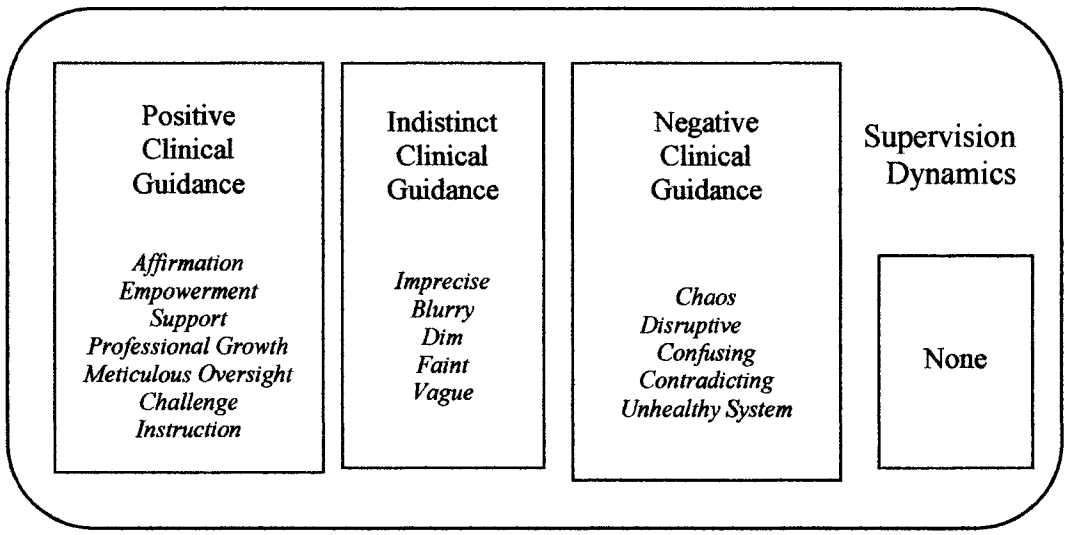


Figure 18. Supervision Dynamics Category Diagram

The four types of supervision experiences illustrated in Figure 18 form the four sub-categories for this category. These sub-categories were formed based upon the direct statements and/or presentation of participant report regarding their clinical guidance experiences, and are not intended as the researcher's assessment of the

reported supervision experiences. Frequency and type of reported supervision experience with selected clients is found in Table 32.

The columns and their totals in Table 32 refer to participant report of supervision experience by clinical guidance category identification. The first sub-category, positive clinical guidance, contains three participants. All three of these participants reported formal individual supervision experiences. The second sub-category reports indistinct clinical guidance experiences and contains eight participants. Five of these participants reported formal individual supervision experiences. Two reported group supervision interactions. One reported a networking interaction. The third sub-category reports negative clinical guidance experiences and contains two participants who were both engaged in formal individual supervision. Placement of one of those participants in the negative supervision sub-category is related to a secondary supervisor within the agency system and not necessarily reflective of his reported primary supervision experience. The fourth sub-category contains the only participant who reported seeking no formal or informal clinical guidance with her selected client case. Superscript symbols for various participants indicate supervision type.

Table 32

Frequency and Type of Reported Supervision Experience with Selected Clients

Participant Identity	Positive	Indistinct	Negative	None
Sarah		X^{G}		
Marti		X^{G}		
Bob			X^{FIS}	
Matthew	X^{FIS}			
Suzy		X^{FIS}		
Daniella	X^{FIS}			
Sam			X^{FIS*}	
June				X
Susan		X^{PN}		
Sally		X^{FIS}		
Jim		X^{FIS}		
Eva	X^{FIS}			
Beth		X^{FIS}		
Bill		X^{FIS}		
Totals	3	8	2	1

Note: Superscript symbols indicate supervision type: X^{FIS} formal supervision; X^{FIS*} formal individual supervision but the negative sub-category designation is about a secondary supervisor involved in the case within the agency not his regular individual supervisor; X^{G} group supervision, X^{PN} peer networking.

Positive Clinical Guidance Sub-Category

The positive clinical guidance sub-category contains data for the three participants, Matthew, Daniella, and Eva. Each of these participants reported positive supervision experiences while working with their selected client cases. Matthew reported a sense of being affirmed and supported through supervision. Daniella reported having a supervisor who gave "meticulous" oversight and was "on it." Eva described her supervisor as "empowering." As they worked through the face-to-face interview, Matthew, Daniella, and Eva each made overt comments about their positive supervision experiences during the decision-making process. Only participants who made clear and direct statements describing positive clinical guidance are included in this sub-category.

Matthew shared that when he was questioning his abilities with Franklin, he would "lean on" his supervision process. He stated, "my self esteem and confidence grew when I spoke to my supervisor." At the point when Matthew reported Franklin's abrupt termination, he shared about his internal self-questioning process and musings regarding his own sense of inadequacy. He summarized his supervisor's response to those questions and musings as follows, "Yes, you were doing everything possible. You know, you are limited somewhat." Matthew shared his understanding of these statements as the supervisor's assuring him that Franklin's resistance, or lack of desire for change, was not a statement about of his competence as a counselor. The key words identifying Matthew's reported supervision experience as positive are support and encouragement. Matthew attributed his positive supervision experience with

increasing his sense of professional confidence and assisting with his professional growth.

Daniella's work with Lucy was done through an intense adolescent program where it was normal to conduct multiple, lengthy sessions per week. She described herself during that period of her professional life as young in chronological age and clinical experience. At the time of the interview she was much more experienced and shared her belief that the experience with Lucy, under this excellent supervision, had given her some important professional building blocks.

Daniella described the supervision that accompanied her work with Lucy at length and with energy:

> After every session, we had to call and fill in our supervisor. She was VERY [caps added to reflect voice tone] good. We'd have to write very detailed progress notes that she would look over. She would read [them] and, if she didn't feel she had enough information to understand, she'd give it back and we'd have to [add] more information. We had group supervision every other week. She was actually really on it, because it was such a crisis program. There was like ten of us, who did this intense work with kids at the time. She was really thorough. I give it to her. At the time I didn't think so, but if I look back on it now and the other supervisors, she was pretty good.

At this point Daniella paused and the researcher used the silence as an opportunity to ask her to elaborate on what the supervisor did that was good. Her reply was filled with enthusiasm and wonderment:

> [She] just was on it. She was just very meticulous about everything. You know and it was very annoying to be young and have someone so meticulous at the time, but she was just very, very meticulous and very thorough and [asked questions like] "did you check this" and "what exactly are her symptoms" all the time. I was so fresh to everything. I wasn't sure [sometimes] so she just made me very thorough in the situation.

"Meticulous" and "on it" are the words Daniella used to describe her positive supervision experience as she worked with Lucy. She spoke emphatically as she shared her perception of her supervisor's involvement in the case as being "on it." The supervision oversight Daniella reported was characterized by supervisor involvement.

Eva was very expressive about her appreciation for her supervisor. When she was adding flow lines to her conceptual map, it appeared she was stuck so the researcher asked, "Any other flow lines that communicate what was going on?" What came next was enthusiastic in tone and verbiage. As she spoke, she began to draw a "squiggly line" around the outside of her map, which virtually encircled the process with supervision. She called it "happy squiggles," and, as she drew this encircling line, she said,

> I think a nice flow line [would be] – and I don't quite know how to represent the flow line because I haven't quite left myself enough room and I would have to do it almost like - happy squiggles all the way around. [This] was the wonderful supervision I had throughout the whole episode. . . . My supervisor was affirming. This was my first big case. My supervisor kept telling me that I was doing really good work and making appropriate challenges and suggestions. But she never once said, "Oh, why don't you do it like this?" There was always a sense of empowerment about my work.

The qualities characterizing Eva's supervision experience as positive are encouragement, affirmation, and challenge.

The conceptual maps created by Matthew, Daniella, and Eva all make significant statements about their positive clinical guidance experience while working with selected clients. Matthew's map (Figure 6) contains a circle located towards the top right-hand side labeled *Knowledge and Experience.* This circle contains five Post-it® notes that signify the importance he placed on his supervision. When he was

describing his map, Matthew spoke of this *Knowledge and Experience* circle coupled with the rounded rectangle labeled *Goals, Tools, Interventions* as his resource areas. As he was describing these two content symbols, Matthew added the words *Pot of Gold* to this area almost as an exclamation point. Daniella's map (Figure 8) contains two content symbols that directly address supervision. The small rectangle just below the middle on the left of the map is one Post-it® note that simply states "*Called Supervisor.*" The content symbol that is significant to this sub-category is the rounded rectangle in the bottom left corner of the map labeled *Importance of Supervision.* The label states, simply and directly, how Daniella viewed this supervision experience. Eva's map (Figure 14) contains the words *Empowered Supervision*, has the "happy squiggles" representing supervision, and the five exclamation points that she added while explaining that the "happy squiggles all the way around" represented supervision.

The characteristics common to the positive clinical guidance sub-category can be summarized by the key words affirmation, empowerment, support, encouragement, meticulous oversight, growth, challenge, and instruction. Matthew spoke of his supervision as affirming. Eva spoke of her experience as empowering. Support and encouragement were valued parts of Matthew, Eva, and Daniella's stories of supervision. Meticulous oversight was Daniella's description word for her supervision experience. Both Matthew and Daniella referred to their supervision as adding to their professional growth. Although instruction was not highlighted in the short synopsis of their supervision reports, it was an integral part of the stories of supervision Matthew,

Danielle, and Eva communicated. As each spoke about their clinical guidance they received, it was clear that instruction was a positive and influential part of their positive supervision experiences.

Indistinct Clinical Guidance Sub-Category

Indistinct is perhaps an odd descriptor for a data set referencing clinical guidance experiences but a suitable broad label under which to capture the supervision experiences recounted by participants in this sub-category. Synonyms for indistinct include such words as imprecise, blurry, dim, faint, and vague. Each of these synonyms reflects at least one of the eight stories of clinical guidance reported in this sub-category. The eight participants in this sub-category, Sarah, Marti, Suzy, Susan, Sally, Jim, Beth, and Bill, reported supervision-type experiences as neither overtly harmful nor remarkably helpful. Five participants in this category, Suzy, Sally, Jim, Beth, and Bill, reported being in formal individual supervision relationships. Neither Sarah nor Marti was engaged in formal individual supervision while working with their selected client cases, but both participants reported processing their concerns in group supervision. Susan was not in either individual or group supervision while she was working with Ed, her selected client case, but she did report networking with a coworker about his case.

Although Suzy reported discussing Patrick in individual supervision, her resolution was completely independent of supervisor input. Suzy shared her movement through the decision-making process as very structured. In referencing her decision to

continue treatment, she stated, "I really did this on my own." In discussing her work with Patrick and the related ongoing supervision, Suzy said, "I do talk to my supervisor about Patrick a lot. Maybe I'm not utilizing supervision that well, but it's kind of more just touching [base] and she says 'Oh, you're doing fine.'"

When Suzy was asked if she would like something different in supervision, she responded, "Yeah, I kind of know where to go with Patrick, but I guess I'd like to know what else to do." She went on to explain that she would like to help build Patrick's self-esteem and added that she also desired some more specific guidance. She said, "I'm not sure if I'm doing it right." Suzy went on to suggest that tape recording, a supervision technique she found helpful in her graduate school training, might be a way to get the specific oversight she wanted. Her honest self-statements about her professional development struggles are interesting:

> I guess if I was forced enough to tape record or take [verbatim type] notes, it would probably be a good thing, but I'm not going to do it unless I'm told to - just because of the work involved. I don't tape. [There is] not even a mention of that [by my supervisor]. It's laziness [on my part], to be honest. When I go home, sometimes I think I should read more books about [Patrick's abuse issue], but at other times it's like, "screw it."

Suzy's characterization of her supervisor as nice but not as challenging as she would like categorizes her supervision experience as indistinct, faint or vague.

Sally reported consulting her supervisor about the two concerns she had with Gail. In the first situation Sally had to make an on-the-spot decision and simply asked her supervisor for input after the fact. She was affirmed in her decision. In the second situation Sally approached her supervisor about using a new technique and reported the following response and her own subsequent actions:

> She had some familiarity with [the technique] and didn't have a problem at all with me doing it. She'd [said she would] be interested in finding out what happened and how it helped. And then I talked to another woman, who was my supervisor in my internship, about the situation. She's much more cautious. She didn't discourage me from [using the technique].

This second supervisor went over some possible risks with using the technique and encouraged her to do some more research. Following these suggestions, Sally did some research by networking with others who had used the technique.

Although Sally presented a rather lackluster supervision experience related to her work with Gail, she responded enthusiastically with an "Oh, yes" when asked if supervision had been helpful enough for her as a LPC to pursue it when she was no longer required to as a LCPC. She said she wanted a supervisor "who would challenge" her. Later Sally indicated she also wanted a supervisor who would be supportive of her abilities and push her to expand her scope of practice. Sally's consultation experience with her internship supervisor was reported with some energy and is one that could be described as proactive, challenging, and even instructive. However, Sally's demeanor when presenting her on-site supervision encounters related to her work with Gail was passive and could be easily understood as a report about an indistinct or imprecise supervision experience.

Jim reported approaching his supervisor on a number of occasions about his concerns regarding Mary. His desire was to refer Mary but he understood that agency policy gave his supervisor final say in referral decisions. Jim indicated that his supervisor wanted him to learn how to handle cases like Mary, and told him she believed he would encounter similar cases in the future. He, however, was convinced

that he and Mary were mismatched as counselor and client. Although Jim tried to implement his supervisor's directions for treatment interventions, he did not agree with her and reported being very relieved when she finally consented to transfer Mary from his caseload. Jim neither overtly criticized nor affirmed his supervisor, but during the face-to-face interview he presented as confused about the value and wisdom of her clinical guidance in his work with Mary.

It would be hard to characterize Jim's presentation of his supervision as either positive or negative. Although Jim worked hard at presenting his supervisor as a well-intentioned person who instructed and encouraged him, his demeanor when describing her interventions belied his frustration with her delay in affirming the referral he requested. He did not indicate that it was positive supervision, nor did he state any overtly negative assessments of his supervisor's interventions. He did present his supervisor's interventions as worthy of consideration, but also belied an underlying secondary and contradicting perception that although her interventions may have been helpful to his overall clinical life, they were not particularly useful with this case. What characterizes Jim's supervision experience as indistinct clinical guidance is his presentation of the experience as a confusing mix of positive and negative.

Beth selected a client case, Anne, from her novice counselor days and reported her supervisor was as a kind, gentle, and caring man who was not helpful. She described her supervisor as a "very nice man" but not instructive or directive enough to be helpful. She attributed this lack of direction to his theoretical orientation, saying,

> My supervisor was a very nice man but I also think he was very much in a client-centered kind of therapy. I think this was a turning point for me in beginning to

> understand how serious a business this is. That this really can be about life and death.

When asked about her supervisor's interventions during her work with Anne, Beth replied,

> I don't remember. I don't remember. He was not a very significant player. [His primary work site was many] miles away, for starters. He was a very kind man and he was really concerned about me. I mean, I do remember when the threat [on my life] came through, that he said you do what you need to do to take care of yourself. [To] tell you the truth, I think in a lot of ways, I educated him about some of this. He'd been out of school many, many years, he was a nice guy, you know. For example when he retired, he shredded all his files – no matter how old or how current. He just shredded them all up. So anyone who was going to pick up working with these people had nothing to go on. That was sort of his mindset. Um, it was really old school. [He was] really a nice man, really gentle, tender, loving man. No, he didn't give me much direction. No one did. This happened earlier on in my career. She was one of my first clients. [It was a] baptism by fire.

She went on to explain that he "added pressure" in reminding her that they were indebted to the facility where they had been given office space and that one of the officials for that facility was very concerned that she would not see Anne. This left her with decisions about explaining the situation to ease tensions in the building or keeping of confidentiality. She stated, "he didn't give me direction about confidentiality issues."

Beth viewed her work with Anne as having a negative outcome for both her and the client, and reflected that if her next supervisor, Martha, had been with her on this difficult and painful case, the outcome might have been different. She said,

> [My work with Anne] happened early on in my career. I wish I'd had Martha at this point because I could have called Martha and said "ahhhhh" *(in kind of a scream).* And she would l have helped me – given me more direction.

Beth worked to present her supervisor in a positive light and yet believed that he was not particularly helpful. Beth did not report any overtly negative or positive assessment of her supervisor. She did present the situation as two people, a novice counselor and passive supervisor, who walked through a difficult time together. His vague, imprecise, and passive supervision characterizes this as indistinct clinical guidance.

Bill, like Suzy, Sally, Jim, and Beth, staffed his selected client case in formal individual supervision. He reported his overall supervision experience was influential in helping him develop his thinking about cases and felt his supervisor's insistence on clarity about diagnosis was important to his professional development. He seemed to appreciate his supervisor's insistence that his treatment plan for Ray be grounded in diagnostic understanding. Bill indicated discussing his boundary of competence concern with his supervisor but came to his resolution for continued treatment during the face-to-face interview. Although Bill indicated he respected and appreciated his supervisor, he presented as a very independent individual who viewed supervision input not as direction or guidance but as interesting food for thought. It is Bill's perspective on supervision and the fact that he came to resolution of his boundaries of competence concern with Ray independent of his supervisor that characterizes his supervision experience as indistinct.

The three remaining participants in this sub-category are Sarah, Marti, and Susan. Sarah and Marti staffed their selected cases, Carl and Doris, in group settings. Susan recalled talking with a peer about her case.

Sarah's group was a supervisor-led group, which was part of the extensive on-going continuing education experience she was engaged in. When asked if she had staffed her work with Carl in her group supervision sessions Sarah initially responded, "No, I never brought him up. I don't think so." After a few moments of silence, she added, "Oh, wait, I did. Yes, I did bring him up." Sarah had explained her concerns about Carl's not giving her cues about his internal process during their experimental exercises. She stated, "I think they were telling me what I was doing was OK. It's OK to be stuck with it." The group process may have delayed Sarah's suggesting a shift in treatment to Carl. Sarah's ethical decision-making process resolution was not influenced by the group supervision experience.

Marti selected a case from her work as an experienced counselor. She reported that she did staff Doris with her peer consultation group. She reported no recall of their input and indicated that the consultation was not useful. It may be worth mentioning here that Marti had reported her peer group supervision in phase one of the face-to-face interview as "not very helpful." She gave it a ranking of two. The ranking scale was one to five, with five being the most helpful and 1 being not helpful. The fact that there was no indication that Marti's group supervision experience was negative, but every indication that was not particularly helpful, characterizes this as indistinct clinical guidance.

When Susan was asked if she remembered seeking supervision around her work with George, her selected client, she responded,

> There was one man [in that work environment] who I would just bounce things off. This man did have DSM training. So, I did talk with him about the [diagnostic] stuff. It was not supervision but a kind of consultation.

What characterizes Susan's networking experience as indistinct is that she did not indicate the consultation interaction as helpful or not helpful, but she did report it as a nice interaction that affirmed her already determined decision-making process.

The conceptual maps for the eight participants reported in this sub-category contain few content symbols referencing supervision. The maps created by Suzy (Figure 7), Bill (Figure 16), Sarah (Figure 3), Marti (Figure 4), and Susan (Figure 11) contain no mention of supervision in content symbols Post-it® notes contained within the content symbols. Beth (Figure 15) placed her one Post-it® note that addressed supervision in her rounded content symbol located at the top and right of center of her map labeled *My system Failures*. Sally (Figure 12) created a rounded square content symbol at the bottom left of her map labeled *My Thoughts and Efforts* and placed a smaller content symbol circle within that larger rounded square. The content symbol circle is labeled *With Supervisors* and mostly references her consultation with her self-initiated consultation with the second supervisor. Jim's map (Figure 13) contains two content symbols that address supervision. The first is the short rounded rectangle located toward the top right of the map labeled *Talked to Supervisor.* The second is the long rounded rectangle located across the map just above the map's mid-point. These two content symbols contain the Post-it® notes detailing Jim's interactions with his supervisor surrounding his desire for Mary, his selected client, to be transferred to another therapist.

Indistinct clinical guidance is characterized by supervision described by participants as neither positive or negative; experienced as confusing or presented as if through blurry vision; reported as too vague, dim, or faint to be clearly helpful; and/or perceived as neither particularly helpful with the selected client case nor significantly harmful. None of the eight participants in this sub-category said overtly positive things about their supervisors and none of them reported or admitted to negative assessments of their supervision experiences. Each of these eight participants found the input from their supervisors as either not related to or not helpful in their ethical decision-making processes.

Negative Clinical Guidance Sub-Category

Two of the participants, Bob and Sam, reported negative clinical guidance experience related to their selected client cases. Both Bob and Sam presented cases in which the supervision became entangled in a number of difficult circumstances that created stormy situations for them as counselors. Although both of these situations were very linked to system dynamics, supervision dynamics were involved in the unsettling case dynamics. The system dynamics are more thoroughly presented in the system dynamics category.

Bob reported constantly seeking supervision in his work with Jennifer. Bob used a significant portion of the face-to-face interview time talking about the pain, upset, and confusion that were the consequences of supervision he experienced as delivering mixed messages, providing no solid guidance, consistently lacking in clarity, and

fraught with disturbing power struggles between supervisors within the system. Bob believed these power struggles and the inability of two particular supervisors to get along negatively impacted Jennifer's well being and his work to help her work through her concerns.

Bob talked about Jennifer's suicidal weekend calls and his efforts to extract some direction concerning them in supervision. He reported,

> I had a supervisor who was the director of the program, and [Jennifer's] psychiatrist was medical director. I didn't get a lot of direction from either one of them. It was keep doing what you're doing and hopefully, she'll show up and she always did. It wasn't that they weren't directing. I don't think they knew what to do either. I think I felt like everybody didn't know. No one knew what to do. So it became kind of keep doing what you're doing. Well, I was not doing anything. And it felt like spinning my wheels in quicksand or just spinning my wheels period. I was sitting there not talking, sitting there for an hour and a half [on the phone] at midnight. The only way I knew Jennifer was on the other side of the phone was I could hear her breathe and I'd think to myself, "is she doing something to harm herself right now as we speak." I'd go take it to my supervisor [again] the next day.

At one point in the interview Bob reported that when he would go to his supervisor about these difficult suicidal calls he would hear "yeah, don't tell anybody that she's calling you, okay, but don't tell her to stop, because you may need that [information] at some point."

Bob talked about the power struggles between two of the supervisors involved in Jennifer's case management and the sudden and secret living arrangement that developed between Jennifer and one of the staff when he was reviewing his conceptual map:

> [The system] became real dysfunctional. This supervisor and this supervisor didn't get along. The supervisors kind of weren't working together. I'm not getting feedback from either one, and I'm feeling lost. People tried to do all this

> stuff but no one was working together. The supervision I got when I first went there was wonderful supervision. So I think that it was these two supervisors - the male and the female - not the psychiatrist, and their inability to get along that crushed, totally destroyed, the teamwork and there was no supervision. This person would say one thing and that person would say another, so it became a system I had to move out of. I couldn't do it any more. During that case I really, really needed a lot of supervision, but I didn't get it. There were too many other agendas going on.

At the end of this set of comments about supervision dynamics, Bob reflected on the difficulties he experienced, feeling lost and confused about his work with Jennifer and the potential on him as a professional. Bob was recounting that this case began his first year out of school and commented on how limited he felt back them. The researcher commented, "you're still in the profession," and Bob unpacked his reflections on the damage it could have cost:

> Yeah, quite amazing [I am still in the profession], but I was single and working a lot. If I had a family, I probably wouldn't have had the energy. I think I would have quit over that. Thinking back on it now, I had a lot more energy then. If I were somebody coming out of school that had a family already, this probably would have [done it]. I'd be selling insurance now because of the lack of direction that I got.

Bob's ethical dilemma involved both the dynamics of Jennifer's presented concerns and the difficult supervision dynamics woven throughout the telling of his story. The characteristics of Bob's negative supervision experience are lack of solid or clear clinical guidance, mixed messages, and negative system dynamics. These supervision dynamics led to Bob's receiving no answers or help and left him with a feeling of being lost.

Sam presented his work with Deb as being fraught with supervision misdirection, confusion, deceit, and conflict that ended up in a negative outcome for

both the counselor and his client. Sam first mentioned supervision in relation to his quandary about his responsibility in regard to the unnamed psychiatrist with whom Deb had reported a dual relationship. Deb had been engaged in a sexual relationship with this doctor while she was also his patient. Sam stated that his supervisor's response was, "If she's not going to give you the name, don't worry about it. Just encourage her [by letting her know] that if she would ever like to report, she can." Sam reported this in a manner that said he respected his supervisor and the advice that was offered.

Some time later Deb presented material about an "affair" with her caseworker. This caseworker was employed in the same agency system as Sam, and thus, he was familiar with the individual's supervisor, who will be referred to as the secondary supervisor. Sam called the secondary supervisor but did not consult his own supervisor. Sam said,

> I left a message on his supervisor's voicemail. I got a call back within the same day and was told, "Sam, Deb has made allegations of this nature before about different caseworkers. Don't worry about it." I called back and said, "maybe Deb should be switched to a female caseworker." The response was, "Oh Sam, it's OK."

Deb continued to talk about her sexual relationship with her caseworker and Sam approached the secondary supervisor again. This time Sam said, "It has been over a month and I know you said before not to worry about it. I am worried about it. I haven't gone to my own supervisor about this."

At this point in the interview Sam paused and said, "This is getting to the ethical part." He then went on to explain that he had not gone to his own supervisor, because

he was worried about getting the caseworker in question in trouble. He said, "She might do something about it. I felt that I had already spoken with his supervisor and I didn't need to speak to mine." Sam revealed that he was also concerned because he had not spoken with his supervisor a couple months previously. At this point Sam said, "It became an ethical dilemma for me."

Sam's concerns were somewhat arrested when the secondary supervisor responded by saying, "Sam, we talked about this already. I talked about this in our supervisors' meeting." At this point Sam explained his relief and rationale for not approaching his supervisor himself about this matter. He said, "I was thinking my own supervisor heard about it and hadn't come to me so I was not going to say any more about it."

Within a short time some additional things happened in regard to Deb and the reported offending caseworker. At this point Sam decided to go to his supervisor. He reported this supervision session and the subsequent events as follows:

> I went to my supervisor and asked, "Did you know anything about this?" [She responded], "No. What are you talking about?" She was very incensed. I said, "This is what happened. These were my interventions. I was encouraging her to report this. She didn't." [My supervisor] immediately went to our clinical director and made a report. During this period of time we had received training that we were to report this kind of incident to some state office. I can't remember the acronym for the office. I forget who you're supposed to report these events to within the state [I was practicing in at that time]. She made the report. I didn't ask about it afterwards. I continued to see Deb for another two weeks. Then I was informed by my supervisor and our clinical director that I was going to terminate with Deb. She was going to see a female therapist. I said, "Is this necessary?" They said, "Yeah, we don't think it's a good idea that you meet with her anymore."

Because Sam's rationale for reporting to the secondary supervisor and not reporting to his own supervisor were confusing in light of his first report of positive interaction with his supervisor, the researcher used some of the phase-four time to inquire about supervision. Sam was asked to talk about his understanding of supervision prior to his experience with Deb. He responded,

> That you talk about your cases with your supervisor. Supervisors give some guidance by telling you if your intervention was right for the situation or not. They encourage you so you know you're doing fine and also talk about agency issues. They talk about your productivity. But [in reality] so much [of my supervision] became more about the business about productivity [than clinical matters]. [Supervision became a business management thing]: Did you write the report for Medicaid . . . did you do your monthly notes on residential clients?

At this point in the interview, Sam reported that his experience of supervision during the time he worked with Deb was mostly about business.

The second question Sam was asked about supervision was, "What do you think was the reason you didn't go to your own personal supervisor?" Sam responded, "I don't know why. I felt I was off the hook when I called his supervisor. If something happened to him [because of his supervisor's response], then something happened to him, but if I tell my own supervisor something is going to happen to him."

Sam reported his negative clinical guidance experience as characterized by supervision misdirection, confusion, deceit, and conflict that ended up in a negative outcome for counselor and client. The negative report primarily concerned a secondary supervisor with the agency system and not Sam's own direct clinical supervisor. Confusion and conflict in both Sam's internal process and the external system he was working in seemed to characterize this negative clinical experience.

The conceptual maps created by Bob (Figure 5) and Sam (Figure 9) vary in their emphasis on supervision dynamics. Bob's map highlights supervision dynamics. Bob placed a rounded square content symbol labeled *Supervision: 2 supervisors working at cross purposes* at the top center of his map. The double-pointed arrows go from the *Supervision: 2 supervisors working at cross purposes* content symbol and the long rounded rectangle labeled *Feeling Lost* and are labeled with the words *No Answers/No help.* The oval content symbol labeled *Out of the loop: Secret* at the end of the flow line illustrates the confusing system/supervision dynamics Bob reported. Sam tucked his experience of supervision in the systems dynamics area of his map. One Post-it® note referencing supervision is visible on Sam's original map. This note is found in the oval content symbol on the right of Sam's map labeled *Offending Social Service Provider.* There are no other overt indicators concerning supervision dynamics on Sam's map.

The characteristics of negative clinical guidance experiences, as reported by Bob and Sam, are chaos, disruption, confusion, and contradicting statements embedded in unhealthy system dynamics. The contradictions that Bob heard in the mixed messages from supervisors contributed to his negative clinical guidance experience. Although it could be argued that Sam created his own chaos, it is clear, from his report, that he was working within a situation laced with deception and consequent chaos.

No Clinical Guidance Sub-Category

June is the one participant who did not seek any supervision for her work with

her selected client case. She selected a case with which she was struggling at the time of the interview. As she proceeded through the interview, it appeared that she was inadvertently using the research interview as a quasi-consultation resource. During phase four June was asked about her thinking on supervision. In response to the question "what is useful about supervision" June said,

> [Supervision] helps with that sense of isolation once you're out there on your own. That's the absolutely most useful thing. Being in private practice can be very isolating. Now when I did agency . . . in between clients, if you were going nuts, you could run out and [interact with colleagues]. You don't have that when you're in private practice. The next useful thing would be just getting somebody else's viewpoint and insight on something that you're struggling with or are confused about.

June was also asked if there was a reason she no longer engaged in supervision. She responded,

> I don't know. I went into my own counseling. I've always had counseling on and off. I went into therapy which I felt was [needed]. It was a money issue too. I felt that I would gain more insight by once again looking at myself and working through some of my own issues rather than paying for formal supervision at this time. I think the more I know about myself, the more I'm aware of my areas of vulnerability. The more connected I am to that deeper part of me, the more effective I can be with clients.

These reflections about the benefits of supervision and therapy seem to fit well with the conclusion June drew in her decision to continue treatment with her client. June decided the real issue was her inner prejudices. She said, "Yes, I will keep her because it's my issue, not hers."

The sole characteristic of this category is the absence of any reported supervision experience in the decision-making process. Although June did not seek supervision related to her work with her selected client, her transcript does contain some

interesting reflections about supervision. It is the absence of supervision in the case presentation and the conceptual map that places June in this category.

System Dynamics Category

The system dynamics category first emerged as significant during interview number three with Bob. Then, almost with a vengeance, the theme stood out again during the seventh interview as Sam told his story. Finally, in the thirteenth interview Beth's impassioned account of her journey with Anne and the multiple social service agencies involved in her case told of the power she believed systems had exerted on her clinical relationship with Anne. These three participants told dramatic stories about the negative impact of systems on their processes with the client cases they selected to present in the face-to-face interview. For purposes of this discussion, system is defined as any structured organization (i.e. agency or institution) established to provide social services and/or counseling to clients. System dynamics refers to the overt and covert interactions between individuals or groups of individuals within a system and/or between two or more systems.

These three dramatic systems scenarios raised an awareness of system dynamics and ethical decision making. Consequently all of the transcripts were analyzed for system dynamics data. In this analysis there were only four participant transcripts that were void of any data related to system dynamics. The four participants who are not referenced in this category are Sarah, Marti, Susan, and June. None of these four participants or their selected clients had any reported connection with social service

systems. Six of the seven remaining transcripts revealed calm, ordered, and/or supportive system environments surrounding the reported decision-making processes.

Bill, the final participant to be accounted for in this category, is the one participant who worked in a system, but his report of the church system differed significantly from the system dynamics reported by the other participants in this category. Therefore, Bill's data is not included in any of the sub-categories for this category. It may, however, be of interest to note that Bill did express a concern about dual-role relationships and his work with Ray. Bill performed his role as professional counselor in a church environment. He also had pastoral duties in this same church and reported concerns about dual roles when working with clients from his church system. Bill did not report these concerns as system dynamics, but rather as a reality that required him to carefully consider his multiple roles.

The system dynamics category contains two sub-categories as illustrated in Figure 19. The first sub-category contains data related to chaotic, disruptive, disrespectful, and/or confusing system dynamics and is titled confusion and chaos. The second sub-category contains system dynamics data in which participants reported client cases situated in agencies they presented as supportive, ordered, facilitating, responsive, and/or respectful of individuals involved in clinical relationships.

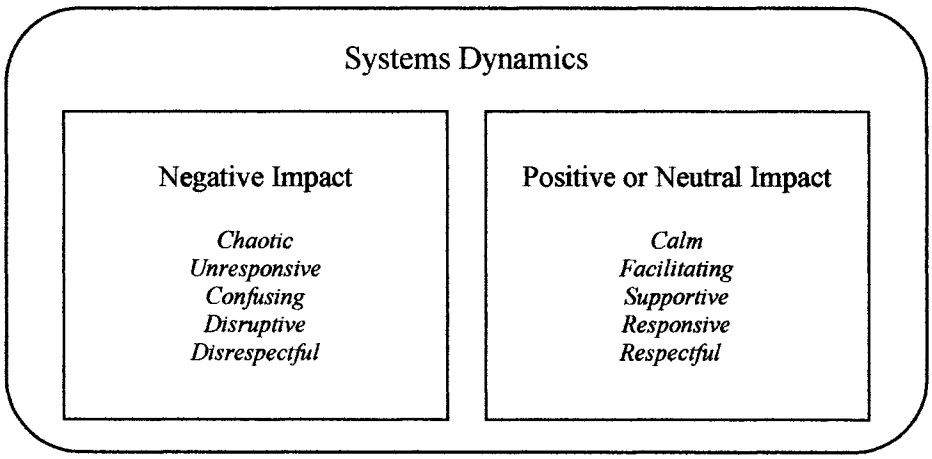


Figure 19. System Dynamics Category Diagram

Negative Impact Sub-Category

Three participants reported in the negative impact sub-category. The overarching words that describe their system dynamics data include unresponsive, disruptive, chaotic, confusing, and disrespectful. Bob, Sam, and Beth told stories about system dynamics negatively affecting outcome for their clients and/or themselves. In each of these client cases participants made it clear they believed negative system dynamics were disruptive to the therapeutic process and either dictated or heavily influenced outcome.

After interviewing Bob, Sam and Beth and analyzing their transcripts, I began to wonder if the dilemmas these three participants described were as much or more about the systems in which their cases were embedded as it was about the clinical material

with which they struggled. The story of Bob's clinical dilemma was about a young girl who was suicidal and non-verbal in sessions. The story of Sam's presenting dilemma was his quandary about how to address his client's report of sexual activity with another agency service provider. Beth's story began with her concerns around her lack of sufficient knowledge about her client's severe mental illness. Each of the three told a second story woven into the first. In each case the "second" story was about systemic confusion and/or chaos.

Bob's story about his work with Jennifer began with his frustration about supervision that lacked sound direction and, at times, was contradictory and confusing. He commented that toward the end of his work with Jennifer the system dynamics "became real dysfunctional." He stated,

> I'm the primary counselor but this other staff person - one of the supervisors - takes Jennifer into her home. Jennifer continued to come to group and we continued to have our [individual] sessions for a short time but there was almost . . . a secret. At that time I felt like "what happened, how'd she get to this new [living arrangement]?"

Bob, who was a young clinician when he worked with Jennifer, believed he was in a system which was not supporting him, because he was not getting clear and competent supervision. He also believed the system allowed personality conflicts among the supervisors to affect the delivery of services. Bob summarized these negative system dynamics at the end of phase three:

> Part of [the dysfunction] may have been due to the times. In the eighties hospitalizations just lasted forever and then that took a downturn. I think the hospital system was starting to shrink. These people tried to do all this stuff, but no one was working together. And then, the system was falling apart. . . . I think that it was these two supervisors' inability to get along that crushed - totally destroyed - the teamwork. One person would say one thing and another person

> would say another so that it was a system I had to move out of. I couldn't do it any more. [Jennifer's] was a case I really, really needed a lot of supervision with, and I didn't get it. There were too many other agendas going on.

The negative system dynamics Bob described are characterized by confusion, conflicting supervision messages, and personality conflicts among various supervisors.

Sam's story had a chaotic feel. The chaos was not just the content of the story but also in the dynamics of the storytelling. At the time of the face-to-face interview, Sam was still in noticeable turmoil about this case. His overall presentation indicated he was lost, confused, and conflicted as he tried to sort out how to balance his ethical responsibilities to his client and the agency.

Sam had selected to present his work with Deb, a woman who reported sexually inappropriate activity with one of her agency caseworkers. Sam had seen Deb some years prior to the face-to-face interview, but during the interview Sam indicated that he was still unclear about the ethics of reporting such situations. He had reported to the offending caseworker's supervisor several times, and each time he had been told to ignore the reports he was getting from Deb. At one point he had been told the matter had been brought up in a supervisors' meeting and informed that he should let it go. However, he was uneasy about these assurances and instructions. When he finally reported to his supervisor, who appeared to be at the same clinical administrative level as the other supervisor, he got very different results. His report was taken up the management ladder and brought back down to him, with significant negative impact.

Sam accepted responsibility for some of the confusion as his own lack of understanding and/or action, but he also held the system responsible because of its

poor management and the systemic dynamics that created an environment lacking clarity. He had reported. He had been told to let it go. He had been told the supervisors had discussed the matter and led to believe his supervisor was at the meeting when Deb's reports had been discussed. His report to his supervisor and the subsequent actions awakened him to the reality that his supervisor had not been at the referred-to meeting. At first he was allowed to continue working at the agency, and when he asked if he should resign, he was told no. Several months later he was discharged. He asked if they were going to report to the licensing board and was told the matter did not necessitate reporting. He did step up and say, "[This matter] is not enough to report to the department of professional regulation but you're going to fire me." Their response was, "We need to separate ourselves from you because of a [potential] lawsuit." In the end he was the one who was disciplined and told he had done wrong. Sam indicated that although all of this did not add up, he still carried an inner sense of confusion and stupefaction about what he "should have done."

The system dynamics reported by Sam are characterized as confusion between agency dynamics and Sam's understanding of reporting policy, which created chaos, and, in turn, negatively affected his client. Sam also reported this situation as diminishing his sense of personal and professional self. The negative impact of the system dynamics left him with a great deal of confusion and an ongoing concern for Deb's welfare.

Beth was passionate in her statements about what she believed were the offenses of the agencies in the broader social service system in which her client case was

embedded. Her client, Anne, was under the surveillance of the Illinois Department of Child and Family Services (DCFS). In addition to her counseling with Beth, Anne had a caseworker at DCFS, was receiving financial assistance services through a second social service agency, and was seeing a psychiatrist at a third agency. Confidentiality among mental health providers in small-town America, poor service delivery in protecting children, the misuse of power on the part of the state mental health system towards the poor, and lack of clear directional supervision are the system offenses Beth cited as she told her selected client case story. Late in the interview Beth commented, "The reality of how human services works is sometimes just appalling."

Beth expressed anger about her experience in a profession that had taken great pains to educate her about protections for clients, but had not provided her with training about how to protect herself. When Anne threatened to kill her, Beth could not recall any training about how counselors can protect themselves if clients threaten their lives. Beth also reported she felt a jolt of reality as she experienced the limitations of law enforcement systems to protect the citizenry. She stated, "you really can't do anything to a person who just threatens to kill you. They actually have to try something before the police will intervene. The system's pretty ineffective in protecting people."

In discussing the agencies involved in Anne's case, Beth talked about her experience that confidentiality in a small town "was a joke in some ways." Beth's office was housed in a church building. The pastor of the church saw Anne regularly. The irony for Beth was that while she was deliberating about her responsibility to keep

confidentiality in regard to informing the pastor about Anne's death threats, it seemed the entire professional mental health culture of her small town, and perhaps her county, were "gossiping" about Beth's need for safety. As Beth was recounting her confidentiality dilemma, she said, "E-v-e-r-y-b-o-d-y knew [about the death threats.] In a really small town everybody, even anyone who is minimally involved, knows everything about DCFS clients because they gossip. I'm really sorry to say, caseworkers gossip." Later she said, "I remember being angry at times. I remember being especially angry over the confidentiality piece. You see, it was a terrible moral dilemma for me."

As Beth explained the story of her work with Anne, the DCFS system appeared to be the system causing her the most angst. Beth reported that immediately before Anne threatened to kill her and one or two DCFS caseworkers, DCFS had placed Anne in some housing in the middle of a drug-infested, gang-dominated neighborhood. Subsequently, DCFS discovered Anne was doing drugs and took her children away. Beth believes this last separation from her children is what precipitated Anne's psychotic episode out of which she made the death threats. Beth had a strong response to the DCFS actions with her client and, during the interview, she also offered some general commentary about her views on DCFS. In the following excerpts from Beth's transcript, editorial comments related to verbal expression have been included in an attempt to more fully capture Beth's emotional presentation. The editorial comments are recorded in italics:

> So I'm working with this woman who is incapable of telling me [her story] because they took away her babies and they never even told me [her primary

> counselor] they were doing this. They never let me know *(sounds biting angry).* It came out of the blue. They took away her kids *(sigh of disgust).* And for a long time it was really hard [for me].
>
> The other thing that happened to me was learning how much DCFC didn't know. A lot of them don't have a background in human services, nor do they know a lot about mental illness.
>
> It's like these DCFS clients have no rights. It's not even human. I mean, I could have sat for an hour and slept and [DCFS] wouldn't have cared. As long as they were sitting in a room with a counselor. . . . It's a tragic system. People talk about foster care. I feel for the kids being abused in foster care, but the parents are abused by the system as well. There aren't many success stories because the system is terrible. I was the only person in the system [in my small town] who cared about the parent who abused the kids. I was the only person who looked out for what might be in [the parent's] best interests. . . . I think I felt dependent on DCFS, and actually, I wasn't. They were dependent on me, but I was too polite at the time. I was in bed with them, so to speak. I crawled out of bed with them.

The agency Beth worked for did provide supervision. Although Beth repeatedly referred to her supervisor as "a nice man," she also described his supervision as "not very helpful." She attributed this lack of professional guidance in part to agency logistics. She worked in an agency that served an entire county. His primary office was 50 miles away from her office and she saw him infrequently. She also believed that the Rogerian approach he used with clients and in supervision was inadequate for circumstances and clinical dynamics like Anne's.

Interagency disfunction, agency lack of extending human dignity, and/or protecting basic human rights characterize how Beth described her experience of negative system dynamics. Beth reported negative consequences for her client as a result of negative system dynamics. The experience resulted in a painful post-outcome

reflection process that required her to expend a great deal of energy sorting residual chaos.

Each of the participants in the negative impact sub-category within the system dynamics category created content symbols in their conceptual maps related to system dynamics they encountered in the selected client cases. At one point, as Bob was describing his map (Figure 5), he pointed to the rounded square content symbol at the top center of his map labeled *Supervision: 2 supervisors working at cross purposes,* and said "this supervisor and this supervisor didn't get along. The supervisors weren't working together. I'm not getting feedback from either one and I'm feeling lost." Sam (Figure 9) created a triangle on the right-hand side of his map formed by his content symbols labeled *Things of Sexual Nature, Offending Social Service Provider,* and *What transpired with services the staff and myself.* He labeled the area *System Dynamics.* Beth (Figure 15) put most of her Post-it® notes addressing system dynamics in the rounded rectangle content symbol labeled *Her Ugly.* She explained that these were "the bad things that happened to her." A number of those Post-it® notes reference DCFS interventions with statements like *"put her at fleabag hotels"* and *"Took kids away."* Beth communicated that she saw Anne as "being stuck in a system that wasn't functioning" and viewed her moving out of the county as Anne's resolution to getting out of the system even though she then lost her kids.

Bob, Sam, and Beth all reported that system dynamics either disrupted or did not adequately support and direct their clinical work. All three experienced system chaos that negatively impacted their selected clients and/or their own sense of professional

self. None of them reported ordered and clinically helpful supervision dynamics. All of them reported difficult aftermath/post-outcome reflection dynamics.

Positive or Neutral Impact Sub-Category

The reader of the negative impact sub-category within the systems dynamic category might respond with an affirming observation something like: "Of course, it is data that should be reported. It is full, direct, and at some points, impassioned." On the contrary, the critic might respond to the data reported in the positive or benign impact sub-category with questions such as: "Is it really there? How did you get that out of this data?" This is because the data for the six participants reported in this sub-category is based on non-verbal presentation and, to some degree, inference. However, one of the goals of qualitative research is to discover and report the meaning in the story (Glaser, 2002). Because there is a striking contrast between tone and presentation of the participants in the negative and positive impact sub-categories system dynamics, the researcher believes there is justifiable reason to form this sub-category.

For purposes of this discussion, a positive or benign system is defined as supportive, ordered, facilitating, responsive, considerate of all parties involved in the delivery of mental health services, and providing resources needed for counselors to work at their clinical and ethical best with each client case. Providing qualified supervision is included in the list of things considered in this discussion of positive or benign system dynamics. To be included in this sub-category, participants need not

have overtly declared the system from which their story emerged as "good" or "positive." In contrast to the negative impact sub-category participants, none of the participants included in this sub-category reported system dynamics that created difficulties for them in their selected client case treatment and ethical decision-making processes.

Data for the six participants included in this sub-category are divided into two areas of consideration. The first contains three participants who reported experiences embedded in social service systems that were benign. The term "benign" in this discussion refers to participant-selected client case stories that referenced the system in some way, but did not indicate the system was in any way disruptive in the clinical and/or ethical decision-making processes. The second area of consideration relates to the supervision that was provided by the system and impacted the client case in a significantly positive manner.

Suzy, Sally, and Jim reported no systemic disruption that interfered with or distracted from their clinical work. Their reports indicated the systems which they served during the course of their work with the selected client cases provided adequate supervision and structure needed to succeed as individual professionals. Suzy did her work with Patrick in a small branch of a very large social service system. At one point in the interview Suzy outlined the agency's policies related to target population groups and their stated limits of service delivery boundaries. As she presented this information, her voice tone and body posture communicated her pride in the agency's clear boundaries. Although Suzy created the solution for her boundaries of

competence concern with Patrick without supervisor input, she reported receiving support from both her supervisor and the system as she moved forward with continued treatment for Patrick. Sally reported working very independently within her mental health practice group and indicated she felt supported by her supervisor as she made choices for treatment. Jim did not verbalize or indicate by inference any upset with having to work to get his supervisor to see the need to transfer Mary to another counselor. He indicated that things were done in order and he was generally pleased with how things turned out.

Matthew, Daniella, and Eva all spoke of their supervision, which was provided in and by the system, as having a significant impact on the work they did with the selected client cases. Matthew worked closely with his supervisor during his work with Franklin. He presented a very ordered process that was supported by his supervisor from the first phone call through his self-doubts after Franklin's abrupt termination. Daniella and Eva both spoke of their work with their selected client cases as positive and infused with guidance from supervisors.

The conceptual maps for participants in this sub-category do not include overt content symbols or statements related to system dynamics. Daniella (Figure 8) created a content symbol entitled *Importance of supervision* and Eva (Figure 14) surrounded her map with "happy supervision squiggles." Because supervision provided by the system naturally becomes part of system dynamics, these conceptual map symbols could be seen as system dynamics data.

The data presented in this sub-category may be seen as almost a deductive line of reasoning or even a back-door approach taken to demonstrate some counterbalance to the negative impact sub-category data. However, the data indicate that at least these six counselors reported satisfaction with clinical process and outcome within agencies providing ordered structure, clear policies, and supportive supervision that gives guidance while respecting independent decision-making abilities of individual professional counselors. These elements were missing for the three participants in the negative impact sub-category, and the presence of one or more of these elements in transcripts of the six participants cited in this sub-category is striking particularly in light of participants' reported sense of well-being at the end of their case reports.

Outcome Category

During the face-to-face interview participants were asked to tell their story from the point they first became aware of their limits to treat the selected client through the process of continued treatment, termination, and/or referral of this particular client. Consequently, generating data about outcome was a natural part of the storytelling process, and therefore, the outcome category is one that could easily have been anticipated. Although the interview instruction may have generated the outcome category as an obvious entity, the data are, nonetheless, interesting and informative. Outcome category data references clinical resolution of the presented boundaries of competence concerns. When present and relevant, data concerning how the

participants selected a particular action for resolution and how participants implemented their decision is included in the outcome category.

Outcome category data is divided into two sub-categories and five sub-sub-categories outlined in Table 33 and illustrated in Figure 20. The first sub-category is designated counselor determination and contains two sub-sub-categories. The second sub-category is labeled client determination and has three sub-sub-categories. Ten participants reported termination as the final resolution to their boundaries of competence concerns with selected clients. The manner of termination, reported in the second column under counselor determination and the three columns under client determination, range from clear and direct counselor-suggested or client-initiated termination to an ambiguous fading away in which clients simply failed to return to treatment.

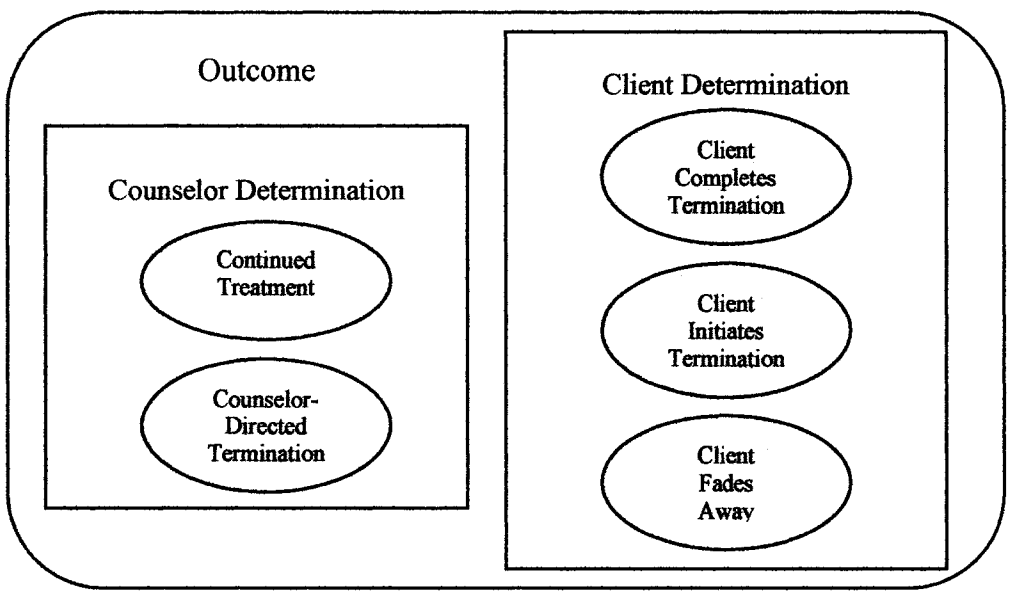


Figure 20. Outcome Category Diagram

Four of the five sub-sub-category columns in Table 33 contain termination as resolution data. Two of these columns contain an X^S symbol. This symbol indicates participant reports of system dynamics heavily influencing and/or dictating the decision for termination as resolution.

The two sub-sub-categories within the counselor determination sub-category are continued treatment and counselor-directed termination as shown in Table 33. Four participants resolved their boundaries of competence concern related to the selected client case by deciding to continue treatment. Termination was determined to be the best resolution for five participants in the counselor determination category.

Five participants reported data within the client determination sub-category, which contains three sub-sub-categories represented by columns in Table 33. The first sub-sub-category is labeled "client completes termination following counselor intervention" and contains three participants. The second and third sub-sub-categories each contain one participant and are labeled "client initiated and directed termination" and "client fades away."

Table 33

Frequency of Reported Outcome Type and Boundaries of Competence Resolution

	Counselor Determination		Client Determination		
Participant	Continued Treatment	Counselor Directed Termination	Client Completes Termination Following Counselor Intervention	Client Initiated and Directed Termination	Client Faded Away
Sarah			X		
Marti		X			
Bob					X^S
Matthew				X	
Suzy	X				
Daniella		X			
Sam		X^S			
June	X				
Susan			X		
Sally	X				
Jim		X			
Eva			X		
Beth		X^S			
Bill	X				
Totals	4	5	3	1	1

Note: X^S in Counselor-Directed Termination and Client Fades Away Columns indicates participants reported negative system dynamics heavily influenced termination.

Counselor Determination Sub-Category

The counselor determination sub-category contains data reported by participants who indicated resolution for their boundaries of competency concern with the selected client case was selected and/or implemented by the counselor. There are nine cases and two sub-sub-categories in the counselor determined sub-category. Four of the case resolutions were continued treatment and make up the first sub-sub-category. Five of the cases resulted in termination and make up the second sub-sub-category.

Continued Treatment Sub-Sub-Category

There are four participants who reported in this sub-sub-category. Suzy and Sally had decided to continue treatment with their selected clients prior to the face-to-face interview and described positive ongoing treatment experiences. June and Bill both appeared to use the face-to-face interview as a semi-consultation experience and during the interview process each decided to continue treatment. All four of these participants reported differing rationales, actions, and/or interventions for implementation of their decisions in reporting resolution to their boundaries of competencies concern with the selected clients.

Suzy was seeing Patrick for schizophrenia-related issues but considered termination when she first heard about Patrick's sexual abuse issues. However, when she discovered Patrick had another therapist with whom he processed this material, she reconsidered. Suzy consulted with Patrick's therapist and together they decided upon a team approach. Suzy would work with schizophrenia-related issues and the

other therapist would concentrate on the abuse issues. Suzy indicated that, as the team approach to continued treatment was forming, her one concern was keeping boundaries clear between therapists, but by the time of the face-to-face interview she reported that they were proceeding with no evident conflicting boundary problems. Suzy had the characteristic of selecting continued treatment in common with the other participants in the continued treatment sub-sub-category, but her continued treatment plan differed from the other participants who selected continued treatment.

In her work with Gail, Sally reported two points in the treatment when she experienced boundaries of competence concerns. In neither situation did Sally consider termination. She was aware of her lack of experience and sought supervision to get direction and information. Gail selected continued treatment following both of her boundaries of competence concern situations with Gail.

June's boundary of competence concerns emerged when Alice mentioned she had sexual feelings towards twelve-year-old boys. As June began her story about Alice, it appeared she did not know what her resolution would be. At the end of the face-to-face interview June was clear she would continue to work with Alice. As she moved through the interview process, June talked through her concerns and developed a rationale for her resolution to continue treatment. The following are some selected portions from her transcript that represent the flow of her process towards resolution within the face-to-face interview:

> I'm not sure yet what I'm going to do. I'm torn because I have a bias against people who are sexual predators. There are people who are much better able to deal with this than I, but I'm also thinking about keeping her because of the alliance we have. And I would keep her because she is different from other

> predators that I've run into. . . . I think that there has been a little shift in how I feel about her [after doing the conceptual map]. I need to try and be more aware of [these new insights]. I think what I'll do is try to be more proactive and try to get her to talk about [her feelings towards twelve-year-old boys]. . . . You know, it takes a long time for clients to trust, which is probably why I don't want to refer her. I know that she'd feel abandoned. That's not something you do unless it is in [the client's] best interest and it is not in her best interest. I can see that [now]. . . . I can see that I am going to keep her. Yes, I will keep her because it's my issue, not hers.

The characteristic June had in common with the other participants in this sub-sub-category was the selection of continued treatment. The unique characteristic June demonstrated in selecting continued treatment was her statement that "it's my issue, not hers."

Like June, Bill selected a client case he was engaged in at the time of the face-to-face interview. During the interview process Bill decided to continue treatment with his selected client for at least the short term. In the course of treatment with Ray, Bill had done a session with Ray's wife and felt his decision to continue treatment needed to include some consideration of Ray's wife and their marital dynamics. As Bill processed through his situation with Ray, he concluded that he would refer Ray's wife for her own individual therapy and use a marriage assessment tool to determine if he would refer them for couples therapy. He concluded his best option was to get the situation down to just working with Ray unless or until he felt Ray's depression was not improving. Bill shared the characteristic of selecting continued treatment with the other participants in this sub-sub-category, but differed from them in his decision to continue evaluating severity of his client's diagnosis (e.g. depression).

Only one of the conceptual maps for the four participants reporting in the continued treatment sub-sub-category contains any content symbol clearly delineating the decision-making process and/or results of the continued treatment decision. Suzy's conceptual map (Figure 7) contains six major content symbols that begin on the bottom of the page. In the middle of her map, Suzy placed a rectangle labeled *Incompetent of Issue.* Above the *Incompetent of Issue* rectangle are three content symbols that address her decision to continue treatment and the subsequent treatment processes. The first content symbol above the *Incompetent of Issue* rectangle is a rounded rectangle labeled *Comfortable with continued treatment due to specialist.* The top two content symbols are rounded rectangles and are labeled *Progress of continued treatment* and *Current Statement.* The Post-it® notes in the top content symbols labeled *Current Statement* read *Comfortable Journey focus on original issue, Client doing well given mix of treatment modalities,* and *With continued treatment, client will be successful.* The three remaining maps (Sally/Figure 12, June/Figure 10, and Bill/Figure 16) which represent continued treatment resolutions all speak to the elements and flow of the therapeutic process as each participant viewed it, but do not highlight the selection of continued treatment as resolution of the decision-making process.

All four participants in this sub-sub-category shared the common characteristic of selecting continued treatment. However, they differed around rationale and/or treatment plan. Suzy selected to continue treatment only after she stumbled upon the fact that her client was already engaged with a second therapist who had a specialty in

abuse. Sally did not report considering either termination or referral. She encountered two boundaries of competence concerns that had immediate resolution within the context of treatment and, perhaps, because of the quick resolutions, had no need to continue termination. June processed her concern during the face-to-face interview and concluded that she would continue treatment. During the interview, she cited her long history with Alice, their strong therapeutic bond, and her insight into her own issues around perpetrators as reasons to continue treatment. Bill decided to continue treatment with a plan for continued evaluation and possible referral at a later time.

Counselor-Directed Termination Sub-Sub-Category

Five participants reported some type of counselor-directed intervention that led to termination of the therapeutic relationship. Only those participants who indicated a process of termination, which was directed by the counselor from the initial termination/referral intervention through the termination and referral process, are included in this sub-category. There were five counselor-directed terminations reported in this study. There were three participants, in addition to the five included in this category, who reported a client-directed termination after the counselor suggested referral as a possible option for their client. However, in each of these situations, the clients eventually self-terminated. The outcome data for these participants is listed in the client determination sub-category.

Marti, Daniella, Sam, Jim, and Beth each concluded their therapeutic relationship with selected clients through counselor-directed terminations. Daniella,

Sam, Jim, and Beth selected client cases from community agency settings. With the exception of Jim, the community-agency-setting stories of resolution include some interface with system dynamics. System dynamics are discussed in detail in the system dynamics category, but because these participants reported the systems and outcome data as intricately linked, the system dynamics will be briefly mentioned in reporting of outcome data for Daniella, Sam, and Beth. Marti is the one participant in this sub-category who did not select a case from an agency setting and who did not report the influence of any system dynamics in the selection or implementation of termination.

Marti presented a client case from a private practice setting. She is the one participant reported in this sub-category with a data set about the process of termination which is to some extent lacking in clarity. In analyzing the data, it was difficult to fully determine whether the counselor indicated concerns about competence, and subsequently, did an intervention terminating the therapeutic relationship or if the client heard the concerns and selected not to return.

It is apparent from the data that Marti began to think about termination and referral several sessions prior to her last meeting with Doris. In explaining her concerns about Doris, Marti stated, "I didn't see anything else that I could do for her other than refer her to a sexual dysfunction clinic." Marti called the sexual dysfunction clinic, had them mail her some material, and subsequently sent the material to Doris. At this point in her story Marti said, "I got that information to her and that was the end." Later in the interview Marti said, "I called [Doris] to make sure she had gotten the materials and I haven't heard from her since." At one point in phase four,

following a probing question, Marti stated, "She had stopped coming and I had told her that I would try and find a suitable place for her." Marti has been placed in this sub-category because of her responses to several probing questions at the end of phase four. These questions were designed to try and discern whether Doris had taken Marti's statements about not being able to help her further and decided not to return to therapy or if Marti actually did a formal face-to-face, counselor-directed termination. Her responses, although a bit evasive, seemed to indicate she had consciously done some sort of an in-session formal termination with Doris. The characteristics Marti has in common with other participants in this sub-sub-category is that she suggested the client consider referral as an option for her concern, she reported a final in-session termination session, and she sought out and shared referral source information.

Daniella reported termination with Lucy as a "difficult," but a well-supported professional experience. When Daniella encountered the dramatic and pivotal situation in which Lucy became violent, Daniella immediately called her supervisor. She received clear direction about procedures for taking Lucy to the hospital. Following the emergency room intake and subsequent hospitalization, it became clear the therapeutic relationship between Daniella and Lucy would have to be terminated, as Lucy would be placed in a long-term residential care facility. According to Daniella's story, her most significant connection with the agency system in which she worked was her supervisor. She indicated several times during the course of the interview that it was her supervisor who helped her "get through" this very difficult termination experience. Although Daniella's termination story differs from the other participants

in this category, the characteristics she has in common with them are her report of initiating a referral by taking Lucy to the hospital, and working with Lucy and her family to transition into final referral.

Sam indicated he suspected early on Deb might be better placed with a female therapist, but he could not get the system to agree. By the time the system was awakened to the reported sexual interactions between Deb and "another [agency] social service worker," Sam felt he had formed a significant therapeutic bond with Deb and did not believe his termination with her at that point was therapeutically in Deb's best interest. However the agency management required Sam to terminate and refer Deb to another counselor within the agency. Deb was very distressed about this abrupt end to her therapeutic relationship with Sam. Although Sam was allowed two weeks to work through the transition, he reported it was not a positive ending for client or therapist. He summarized the termination as follows:

> I met with Deb another two times [after being told to terminate and transfer her case]. She was crying hysterically. She said, "I don't want you to tell them. I told you I didn't want you to. I had asked you not to say anything to your supervisor. I don't want another therapist. I thought we were working well together. "And I said, "I don't have a choice. You have to meet with [the other counselor]."

At the counselor/client level this termination was counselor-directed, but from a systems perspective it was clearly system-initiated, system-directed, and system-enforced. Although the termination of Sam's relationship with Deb was system-mandated, the characteristic Sam had in common with the other participants in this sub-sub-category was his carrying out the termination and referral processes directly with his client.

Jim, like Sam, came to believe early on in his therapeutic relationship with his selected client, Mary, that her therapeutic needs would be better served by someone else. He had approached his supervisor on several occasions about his discomfort in working with Mary. He requested for Mary to be transferred to someone else's caseload. The first several requests were turned down, but in the end, Jim was able to convince his supervisor that Mary should be transferred. Jim made the interventions for termination and referral in one session. Jim's resolution can be characterized as counselor-initiated and counselor-directed termination and referral.

Beth reported the termination of her client, Anne, as an extremely difficult time in her professional life. Anne received services from multiple agencies, and Beth reported the outcome as being negatively affected by interagency system dynamics she believed were damaging to her client's well-being. After Anne threatened to kill Beth, all of the professionals involved with Anne's case concluded that the therapeutic alliance was broken and the relationship should be terminated. It is unclear from the data how Anne was told that her therapeutic relationship with Beth had been terminated. During the course of the interview Beth gave voice to questions about how much of her own inexperience as a young professional counselor had kept her from intervening for her client with the system and perhaps changing the outcome. Beth, like Sam, reported a system-directed termination. Although Beth did not report a termination intervention with Anne, she did make it clear that she agreed not to see her and participated in the arrangements for the termination.

Three of the five participant maps in the counselor-directed termination sub-sub-category contain one or more symbols that overtly represent the termination process and/or decision. Marti's map (Figure 4) contains a large long rounded rectangle labeled *Practical: Referral when unable to take client any further into insight.* Daniella's map (Figure 8) contains a long narrow rounded rectangle content symbol labeled *Termination with Client* and is linked by a directional arrow to the small square content symbol labeled *Called Supervisor.* Jim's map (Figure 13) contains two content symbols that reference the termination with his client. The narrow rounded rectangle toward the center of the map, labeled *Lost/Transfer,* contains Post-it® notes outlining Jim's requests that led to his supervisor finally giving consent for a transfer. The bottom content symbol of those connected by flow arrows is a rounded rectangle labeled *Finish up Job done* and contains the Post-it® notes describing the termination process.

The two participant maps in this sub-sub-category that do not contain content symbols overtly labeled to indicate termination are Sam's and Beth's. Sam tucked the termination events in his map (Figure 9) within the content circle labeled *What transpired with services, the staff, and myself,* which is one point of the *Systems Dynamics* triangle he formed using three content symbols. Termination as resolution for Sam could not be separated from system dynamics. Neither Beth's map (Figure 15) nor her map description directly addressed the events at the end of the therapeutic relationship. There are two oval content symbols labeled *My Resolution* and *Her Resolution,* which at first glance, appear to speak about resolution. The long oval at

the bottom right of the map is labeled *Her Resolution* and contains two Post-it® notes telling the story of Anne moving out of the area, having her kids taken away, and refusing any further treatment following Beth's refusal to see her. The shorter oval in the middle and at the right of the map labeled *My Resolution* is not about the termination but about the aftermath for Beth and contains her resolutions and understanding that have informed her subsequent work.

All four of the counselor-directed terminations reported in this category are characterized by counselor actions that directly or indirectly terminated the therapeutic relationship and resolved the boundaries of competence concern. Marti and Jim planned the termination and referral transitions and took direct actions to implement their plans. Daniella, following the direction of her supervisor, was indirectly involved in the decision for termination but directly involved in the transition of referral. Although Sam directly implemented the termination and referral process with Deb, it was not his plan. Sam was told by the agency that he would terminate and had to do so immediately. Beth was indirectly involved in the termination process with Anne. She agreed that it was a dangerous situation and that termination was necessary but never got to say good-bye to her client in a termination and referral session.

Client Determination Sub-Category

The client determination category contains data reported by five participants who indicated outcome for each selected client case was directed by the client. All of the

cases reported in the client determination category ended in termination of the therapeutic relationship but vary in the process that unfolded ending the relationship. This category contains three sub-sub-categories. The first sub-sub-category is labeled "client completes termination following counselor intervention" and contains three participants. The second sub-sub-category is labeled "client-initiated and directed termination" and contains one participant. The third sub-sub-category contains one participant and is labeled "client fades away."

Client Completes Termination Following Counselor Intervention Sub-Sub-category

Three participants reported in the client completes termination following counselor intervention sub-sub-category. All of these participants, Sarah, Susan, and Eva, reported directly speaking with their clients about their own sense of limitation with material being presented and/or suggesting the possibility of considering referral. The manner and time of termination following these interventions varied, but in each case the client directed the final outcome.

It is worth noting that there were two additional participants who indicated having shared their boundary of competence concerns with their selected clients. These two participants, Marti and Suzy, are not included in this sub-sub-category because neither of their outcomes was reported as client-directed termination. Although Marti indicated mentioning her concerns to Doris on a number of occasions prior to their final session, she reported her termination with Doris as counselor-

directed. Suzy had also shared her concerns about abuse material with her client, but had been able to find a solution that facilitated a continued-treatment resolution.

Sarah reported the shortest lag time between revealing concerns about limitations and client termination. Although Sarah reported being conscious of her concerns early on in her work with Carl, she indicated only mentioning these concerns and offering a possible alternative therapist to him in what turned out to be their last session. Sarah described her intervention concerning a possible referral as follows:

> I think he was starting to come less often [perhaps because of financial limitations] and I said, "let me just run this by you. I went to this person [for counseling] and I think that he really did pull some rage and bitterness out of me. I feel better. And I think, if you're interested [he might help you too]. Here's his number if you're interested." I didn't say he had to stop coming to me. I didn't say it was me or this guy.

Characteristics of Sarah's reported outcome were the sharing of her boundaries of competence concern, suggesting a possible referral, and having her client not return for treatment, which terminated treatment.

By the third session with George, Susan reported, "I was very concerned this was going to be something beyond what I can do." Susan had only contracted to do career counseling with George and had gained information in the second session indicating a serious mental health concern. At the third appointment Susan stated she told George,

> I really feel that you're going to need to deal with [your mental health concerns] before we can make progress on the career counseling. I'm not going to refuse to see you because you'll find somebody else and do the same thing. What's going to happen is you're going to be telling me after another two or three appointments that I have failed. You don't have a job and it's my fault. You're wasting money you don't have.

Susan reported that his response was "no, he wasn't going to go to anybody [for mental health counseling]."

Three or four sessions later Susan's words were validated. She continued the termination story in these words,

> Well, exactly what I predicted happened. . . . He did come three more times, and we were strictly working at that point on just job search process, strategy and plan, trying to help him with the tools and that kind of thing which is exactly what I told him I would do and nothing more. . . . He was not getting anywhere, which I knew would happen, and then he got mad. He got very mad, angry. He said, "you're not doing any good. I'm paying all this money and . . . ." I said, "I understand that and I agree. I would still like to refer you if you want a referral or I suggest that you go back [to your previous mental health counselor] because there's a bigger issue here." He stopped coming. And I don't know if he ever went to anyone to deal with the [mental health] disorder.

Susan's outcome with George was characterized by her sharing of her concern, her suggestions for referral, her prediction of his anger about his perception that she had failed, and his subsequent failure to return for treatment.

Eva was working in an agency that focuses on bereavement issues and typically limits clients to around eight sessions. Eva began sharing her boundary of competence concerns and agency session limits with Ed in the fifth session saying, "if things don't shift, we need to refer because the grief has surfaced something else [which is beyond our agency purpose]." His response was, "I can really work with you and I'm not shifting. I'm not going to somebody else." Eva stated that after this initial overt intervention, which was intended to lay the groundwork for termination and perhaps referral, the wrap-up for each subsequent session would include a reminder that "this is brief grief work." She gave him some referrals. These referrals included three men and a woman. Eva reported she was careful to include a women referral option as he

had stated in his first phone conversation with her, "I work better with women than with men." After nearly a year of treatment, which included eighteen sessions, Ed announced he had begun to do some work with a gentleman whose specialty was with cancer patients, but, interestingly, was not one of the referrals Eva had given him. At this point Ed attended less frequently and Eva felt they were "winding down." She described the end of therapeutic relationship as follows:

> He was coming in and saying, "I don't even know why I'm here anymore. I'm really doing better." And so I suggested that if he was starting to wonder about that, maybe it was time for us to start thinking about wrapping up sessions. And he said, "OK, I'll call you." I've never heard from the client again. And interesting, he was not there when his wife died.

Eva's reported outcome with Ed is characterized by her sharing her concerns and offering referral options coupled with Ed's resistance, which was followed by his abrupt telephone announcement that he was terminating with her and had engaged with another therapist.

Two of the three participant maps in this sub-sub-category contain a content symbol dedicated to the resolution of the clinical relationship. Sarah numbered the content symbols in her map (Figure 3) to indicate the sequence of occurrence. The final content symbol labeled *Resolution is referral: That's where he started (5)* contains the Post-it® notes recording the data about the last session, as well as some information Sarah gained about Carl's ongoing counseling with the gentleman she referred him to. Marti's conceptual map (Figure 4) contains one large rounded rectangle at the far right of the map labeled *Practical/ Referral when unable to take client any further into insight* and contains the Post-it® notes that outline the referral

process. Eva's map (Figure 14) does not contain any content symbols that exclusively address the outcome of the selected client case.

The common outcome characteristics of the client completes termination following counselor intervention sub-sub-category are counselors sharing their concerns and suggesting referrals and clients subsequently terminating the process without allowing for counselor closure. Sarah and Susan reported client cases involving clients who terminated in an indirect manner by simply not returning for treatment. Eva reported termination as an event, which was initiated by the client over the phone in a very direct manner.

Client Termination Sub-Sub-Category

One participant, Matthew, reported a direct client action that led to termination of the therapeutic process with no prior counselor indication of a sense of boundary of competence concerns, termination, and/or referral. Matthew had worked with Franklin for about four months, done a lot of networking to obtain additional support services for Franklin, and reported continually running into resistance. Because he had questioned his competence with Franklin and was committed to continuing treatment, Matthew had discussed this case regularly in supervision.

One day Matthew received an informative call from a volunteer who was working with Franklin. The volunteer stated Franklin had told him he wanted the volunteer to stop coming. This information prompted Matthew to initiate a call to Franklin inquiring about the matter. Matthew reported the following statement

fragments from the phone conversation that marked the client-initiated termination and consequent end of their therapeutic relationship:

> I want everybody to leave me alone. This is too much. This is too overwhelming. I want to continue to be isolated. I want to continue to be a victim of my [difficulties] and I pray for my day to come. I've had 80 years of [happy life] and what do I do now. I am unhappy. Matthew, thanks. You're a great person, but things are not changing.

Matthew's conceptual map (Figure 6) does not overtly speak to Franklin's termination. The Post-it® note reading "Franklin terminated. He wanted to be alone" is encased in the rectangle at the top right of the map labeled *Final Thoughts "As I move Forward."*

Outcome for Matthew was characterized by his client's direct statements related to being done with treatment. Matthew had not shared his concern with his client and his client did not want to continue in treatment of any kind and, thus, was not open to referral suggestions.

Client Fades Away Sub-Sub-Category

Bob is the only participant who reported a client case where there was no discussion of the counselor's competence concerns, no discussion of termination and/or referral, and no direct action on the part of the client to terminate the therapeutic relationship. His therapeutic relationship with Jennifer had spanned several years, including inpatient and outpatient individual and group work. Bob reported the ending of their clinical relationship as an elusive fading away.

Towards the end of his therapeutic relationship with Jennifer, Bob reported the presence of some confusing system/supervision dynamics that seemed to have superseded his long-term work with Jennifer. These dynamics also sidestepped any sense of teamwork within the system Bob was serving and in which Jennifer was being treated. Bob reported a sense of confusion about just what happened when Jennifer stopped presenting for treatment a short time after she moved in with another professional from the agency. Bob captured the essence of this elusive ending while musing about the end of his relationship with Jennifer. He said, "And so, did we ever say goodbye? No. It, our therapeutic relationship, just kind of went away. [It] faded."

Bob's conceptual map (Figure 5) contains a content symbol and statement that communicates his view on the ending of his relationship with Jennifer. The oval content symbol to the right of center in the bottom half of the map labeled *Out of the loop Secret* contains the Post-it® note indicating Jennifer went to live with another staff member. The label itself clearly describes how, after several years of intensive therapeutic work with Jennifer, Bob felt left out of the why's and how's of Jennifer's not returning to treatment. The statement to the left of center in the bottom half of the map that states *I was primary counselor but this person – out of nowhere- takes her out of her home – Lost* also illustrates Bob's sense of bewilderment at the end of the process.

A characteristic of Bob's reported outcome is the lack of opportunity for closure when his client simply faded away. Bob did not share his concern with his client, he

did not have opportunity to offer referral options, and he reported a deeply felt sense of lack of closure.

Aftermath/Post-Outcome Reflection Category

It could be said the aftermath portion of this sub-category title was given voice by Sam in interview seven. It was Sam who labeled the final content symbol in his conceptual map (Figure 9) *The Aftermath.* The aftermath/post-outcome reflection category contains data that pertains to post-resolution or post-outcome reflections. These reflections reveal a mix of satisfaction, dissatisfaction, unsettledness, conflict, and growth.

The aftermath/post-outcome reflection category, sub-categories, and sub-sub-categories are illustrated in Figure 21 and outlined by participant report in Table 34. The first sub-category contains data gathered from participants who reported a sense of satisfaction with the process and its outcome and contains data from eight participants. The satisfied with clinical process sub-category has two sub-sub-categories: continued treatment and therapeutic relationship terminated. The second sub-category reports data from participants who indicated dissatisfaction with the process and/or outcome dynamics and contains data from five participants. The unsatisfied/unsettled about outcome dynamics sub-category has two sub-sub-categories: lack of closure and conflicted and/or in pain. For some participants who were unsatisfied with the outcome dynamics, there was an uneasiness with the lack of closure but for others it was a more poignant aftermath of conflict and/or pain. The

third sub-category contains participant post-outcome reflections about professional growth that resulted from their work with the selected client and contains data from five participants.

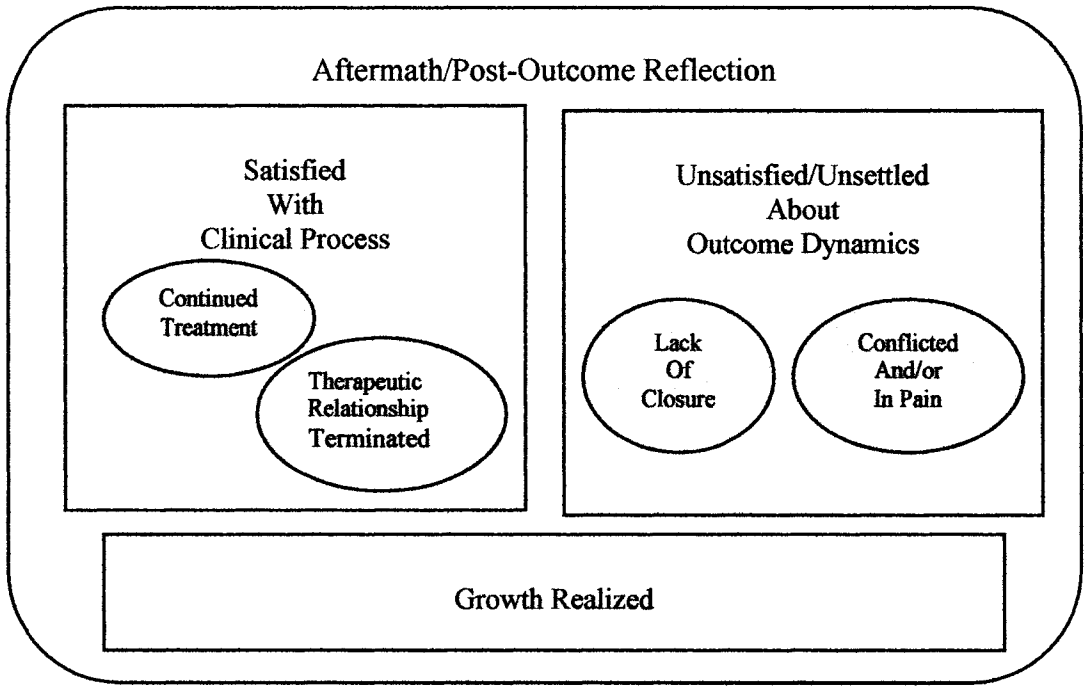


Figure 21. Aftermath/Post-Outcome Reflection Category Diagram

Table 34

Frequency of Reported Aftermath/Post-Outcome Reflection Type and Boundaries of Competence Resolution Categories and Sub-Categories

	Satisfied with Clinical Process		Unsatisfied /Unsettled About Outcome Dynamics		Growth Realized
Participant Identity	Continued Treatment	Therapeutic Relationship Terminated	Lack Of Closure	Conflicted and/or in Pain	
Sarah		X			
Marti		X			
Bob			X^S		X^S
Matthew			X		X
Suzy	X				
Daniella		X			X
Sam				X^S	
Susan		X	X		
Sally	X				
Jim		X			
Eva		X	X		X
Beth				X^S	X^S
Totals	2	6	4	2	5

Note: X^S Conflicted and/or in Pain Column indicates participants reported negative system dynamics dictated or heavily influenced termination.

Satisfied with Clinical Process Sub-Category

The satisfied with clinical process sub-category reports data from eight of the participants. Suzy and Sally reported satisfaction with the clinical process and thus are listed in the continued treatment sub-sub-category. The six participants who reported in the therapeutic relationship terminated sub-sub-category had a variety of termination experiences but in each case participants indicated a sense of satisfaction with the overall clinical process and/or their role in the delivery of treatment.

Continued Treatment Sub-Sub-Category

Both Suzy and Sally selected to continue treatment with their clients and reported satisfaction with this resolution. During phase four, I reflected to Suzy, "It sounds like you feel really good about how you handled this case, how it came out, and how the continued treatment is going for you and for him." To this reflection Suzy responded, "So far. . . . As far as our process, I think it's going well." Later in the interview she shared some more of her enthusiasm about her ongoing work with Patrick:

> I see him most every day and every day he is doing so much better than when I first started with him. He used to be like this zombie, just flat affect. One of the things he used to do when getting abused was dissociate. He said he'd blend into the wall and watch what was happening to him. And you could just see it in his face. He was just always like no emotion, no feeling, nothing. And now he's got life and friends. So many people give him hugs in the day.

Sally evidenced the same kind of enthusiasm and excitement for her client and the work they were continuing together. She reported,

> If I listed twenty aspects of her life that weren't working a year and a half ago, [you would see how] she is blowing herself out of the water. I mean, she's in college now, she has gotten a raise at work, and she has gotten married to her children's father. When I first started working with her, she had never told anyone in her life that she loved them. And now she tells her kids all the time that she loves them. She thought that getting married and her relationship with her boyfriend was just [frightening and awful], but now she really cares about him.

Suzy or Sally's conceptual maps both highlight the process of treatment with their selected client cases. Suzy's map (Figure 7) clearly delineates the continued treatment process in the final row of Post-it® notes at the top of the map. The notes read, *Comfortable Journey focus on original issue, Client doing well given mix of treatment modalities,* and *with continued treatment, client will be successful.* These notes can easily be understood as a summation of Suzy's satisfaction with her resolution to her boundaries of competence concerns. Sally's map (Figure 12) is a web of lines and content symbols depicting the client's clinical presentation and Sally's interventions. The map does not overtly depict the dynamics of the aftermath/post-outcome reflection category.

Aftermath/post-outcome reflection processes reported by both Suzy and Sally were characterized by enthusiasm and excitement about their continued treatment resolutions. Both reported a sense of satisfaction with both the clinical and outcome processes.

Therapeutic Relationship Terminated Sub-Sub-Category

There are six participants who reported termination as outcome and also indicated satisfaction with the process and/or outcome for their selected client cases.

Three of these participants reported in the counselor-directed termination sub-sub-category under the counselor determined sub-category of the outcome category. Three of the satisfied participants reported data in the client completes termination following counselor intervention sub-sub-category under the client determination sub-category of the outcome category.

Marti, Danielle, and Jim all reported counselor action that led directly to termination of the counseling relationship. Although neither Marti nor Daniella spoke directly to this theme, their general presentation as they talked about the termination events indicated a sense of satisfaction with the outcome. Marti indicated at a number of points in the interview that she was pleased with how she had managed the therapeutic process, termination, and referral with Doris. Jim explained that after he had finally convinced his supervisor about the need to refer Mary to another counselor, his termination with Mary was a one-session event. Mary was transferred to a female counselor she had previously seen in group therapy. Jim indicated he felt this was a good choice for Mary. In response to the researcher reflecting, "It sounds like you feel very good about this outcome," Jim responded, "Yes I do. I do. Glad to be done with that one – very glad."

Daniella reported a termination that was a process solidly supported by her supervisor. After the emergency hospitalization, Daniella had a couple of sessions with Lucy in the hospital. At the encouragement of her supervisor she did what she called a "transition ride" with Lucy to her new long-term residential placement. Daniella also saw Lucy's parents several times to assist them with their daughter's

transition and reported that her supervisor had joined them for the last two sessions. Finally, she reported talking with Lucy twice via phone at her new residential facility. In describing this process, Danielle's presentation took on a calm and settled clarity. This tone of satisfaction emerged as she turned from the chaos of her tale about the crisis moment with Lucy that caused the emergency hospitalization to the sequence of events that made up an ordered and well-supported termination process.

There were three participants who communicated a sense of satisfaction with clinical process and/or outcome with their client-directed terminations that followed some intervention indicating boundaries of competence concerns. Sarah, Susan, and Eva all presented a positive attitude in reporting the resolution to their boundaries of competence concerns with their selected clients.

Sarah explained that after Carl had engaged with his new counselor, Terry, she both spoke with Terry and encountered Carl at a public event. She was excited about the progress Terry reported to her in regard to Carl. In relating her post-outcome encounter with Carl, Sarah remarked with a sense of delight, "Carl looked pretty happy."

At the time of the face-to-face interview Susan talked about George's termination appointment as a matter of fact. She had encouraged him to see a mental health counselor but he had refused. She had told him he would end up angry at her and would blame her for his lack of progress. According to Susan, her prediction came true. George got angry and terminated. This case occurred many years prior to Susan telling her story in the face-to-face interview. She did not report how she felt at the

time of the events, but during the face-to-face interview, she communicated a balanced sense of being an ethical counselor who knew how the situation would end but worked the process well along the way. There was a clear presentation that communicated satisfaction with her role in the relationship in spite of her client's refusal to follow her guidance.

Eva had suggested to Ed on a number of occasions that they needed to begin to wrap up their work together. She had suggested he accept a referral and continue his work in another setting, but Ed had insisted he would not see anyone else. In what turned out to be their last session, Ed announced he was engaged with another therapist. Eva presented this information in the face-to-face interview as if it was a bit of a shock. She suggested they do a termination process. Ed said he would call to set up their next appointment but never called or returned. Eva suggested Ed didn't do good-byes and referenced the fact that he was not present when his wife died after a long battle with cancer. During the fact-to-face interview Eva said, "I think I did the best work I could with him." As she ended her story saying, "OK, that's the story morning glory," the tones of satisfaction were clear. Eva reported being satisfied with her clinical work with Ed.

Only one of the six participants in this category highlighted the aftermath/post-outcome reflection element on their conceptual map. Sarah (Figure 3) placed the Post-it® notes about her positive post outcome interchange with Carl's new counselor and her post-outcome encounter with Carl in the oval content symbol labeled *Resolution is referral: That's where he started (5)* at the top of her map. Neither the content

symbols nor the Post-it® notes within the symbols for the conceptual maps created by Marti (Figure 4), Susan (Figure 11), and Eva (Figure 14) relate any information about the aftermath/post-outcome reflection category data. Daniella delineated her aftermath/post-outcome reflection process within the rounded rectangle content symbols labeled *Termination with Client* and *Importance of Supervision* on the bottom half of her map (Figure 8). Jim is the one participant in this sub-category who made a clear aftermath/post-outcome reflection category statement within his conceptual map (Figure 13). His one Post-it® note that reads *Glad to be done* is encased in the rectangle labeled *Finishing Touch* at the bottom of his map.

Marti, Danielle, and Jim all reported a sense of satisfaction with their clinical work and resolution to take actions that led directly to termination of the counseling relationship. Their reported aftermath/post-outcome reflection processes demonstrated that satisfaction.

Unsatisfied/Unsettled about Outcome Dynamics Sub-Category

The unsettled/unsatisfied about outcome dynamics sub-category contains two sub-sub-categories and reports data from six participants. The first sub-sub-category is entitled uneasiness/lack of closure and contains four participants. The second sub-sub-category is entitled conflicted and/or in pain and contains two participants.

The two sub-sub-categories provide the reported aftermath/post-outcome resolution experiences and emotional responses along a continuum from uneasiness to painful conflict. Because participants reported their aftermath/post-outcome

experiences and feeling responses on a continuum, it was difficult to divide material into clearly delineated sub-sub-categories. Therefore, the somewhat arbitrary division is acknowledged from the outset of discussion of post-resolution reflections. Additionally, participant responses reported in this sub-category refer only to the aftermath events and post-outcome reflections. For example, Bob reported his experience of the treatment process with Jennifer as full of painful conflict, but while his report of the aftermath/post-outcome reflection process was emotional, it was less conflicted and more stable then his presentation of the treatment and outcome processes.

Uneasiness/Lack of Closure to the relationship Sub-Sub-Category

Bob, Matthew, Susan, and Eva all conveyed a sense of uneasiness related to the lack of closure with their selected client cases. These four participants reported various types of termination experiences and thus were listed in different sub-categories or sub-sub-categories within the outcome category. Bob was the only participant of the five listed in this sub-sub-category who reported termination as the client fading away. Matthew, Susan, and Eva reported terminations that involved client statement terminating the relationship, and all three indicated a sense of unsettledness about the lack of opportunity for closure. In addition, Beth, who reported data reflecting a counselor-directed termination, related having strong feelings of unrest related to the termination that did not involve a process of closure. However, Beth's response to the outcome with her selected client case was beyond unsettled and therefore, the data

related to her aftermath story is reported in the conflicted and/or pain sub-sub-category.

As Bob unfolded the story about his relationship with Jennifer, it became clear that closure for the therapeutic relationship was an elongated process that haunted him for a number of years. Bob reported 13 years of experience as a professional counselor at the time of the face-to-face interview. He clearly outlined the time period of his relationship with Jennifer in stating, "[It] was in my first year out of school. [I was] about a year out of school when all [the stuff with Jennifer] started so I'd had pretty limited [experience]." He reported working with Jennifer for three to four years; therefore, it had been around ten years since this case had ended without formal resolution or solid closure. He was still very emotionally engaged with the material as he told his story during the interview. As he talked about the aftermath circumstances and feelings related to their clinical relationship he shared the following events and thoughts:

> Did I ever say good bye? I ran into her. It was weird. I went looking for a lady that I had worked with in storing a boat. When I went to her house and knocked on the door, Jennifer answered. She was living in the basement apartment and she didn't want to talk to me. I remember feeling very hurt. I'd put all this effort [into her well being] and she didn't want to talk to me. Well, [sometime] later I ran into her again. I now think [the first encounter] was just a bad day [for her]. The second time she shared a little bit more about what was going on with her life and I was able to get some feedback. That was right before she moved away. Then I started getting cards. And so did we ever say goodbye? No. It, our therapeutic relationship, just kind of went away, faded without [closure] because of the way the system was set up and my still being new. If I had been in the job I am now, I would have done things a lot differently and been able to track her, or not track her, just to have some closure. [Her transition to the home of another staff worker] was a secret. Boom, [she was gone]. I was the therapist, but this lady took over and still takes a lot of the credit for where Jennifer is at now. It took me a couple of years to get over that. She can have the credit and I'll know

> I did [a lot]. So I was frustrated when I got the last card which was for [her college] graduation because I would have liked to have written a letter, sent her a card, let her know I cared, and said congratulations, great to see you doing this. But she didn't put her return address on it. That could have been some closure, I guess, for me. But I thought she's sending this card and then I have no way of responding. University graduation and she didn't send a return address and I just really would have liked to have sent a card, congratulations, you did great, it's good to see [you did this] . . . that kind of thing. I want to say that was three years ago and I kept the card. The card has been on my desk. I think I finally threw it away right before Christmas this year. I was cleaning up and said, "you know, I've kept this card. I've looked at it and there's not going to be an address [appear on it] *(laughs awkwardly).* So I finally tossed it.

Bob's aftermath/post-outcome reflection process was long and difficult. It was characterized by struggle to come to terms with the conflicting supervision dynamics, system chaos and lack of closure.

Matthew, Susan, and Eva each gave voice to their sense of unsettledness due to the lack of closure with their selected clients. After Franklin abruptly terminated his relationship with Matthew, the following questions formed Matthew's unsettled ruminating, "Was it something that I was doing? Was it my inexperience [with this client population]? What more could I have done?" During the discussion of his map, Matthew said, "I guess all the groundwork just fizzled out. It was a very intense case." Eva offered the following thoughts about the lack of opportunity for closure with Ed:

> It's left me feeling, um. . . [*At this point Eva's words trailed off and she appeared to be sitting with her thoughts and feelings.*] I think I did the best work I could with him, but I've also wondered how I could have encouraged him to stay with the prospect of termination interviews. [Which would have provided] that formal closure. It really was more for me. I have a sense of, well, where do you go from here with this kind of thing, a sense of incomplete . . . just not complete.

Only two participants' maps in this sub-sub-category contain content symbols referring to the aftermath/post-outcome reflection process. Bob's (Figure 5) map

contains a square content symbol placed in the upper right-hand corner labeled *Reconnect* containing the Post-it® notes referencing the several post-treatment chance encounters and/or client-initiated updates via mail Bob had with Jennifer after formal treatment had stopped. The rounded square content symbol labeled *Unfinished Business* at the bottom and left of center in Matthew's map (Figure 6) encases the Post-it® notes outlining his unsettled post-outcome ruminating. The *Unfinished Business* label gives voice to Matthew's unease with the lack of closure and circumstances of termination. Eva's map (Figure 11) does not contain any reference to her aftermath/post-outcome reflection.

Each of the participants in this sub-sub-category reported aftermath/post-outcome reflection processes, which had the common characteristic of uneasiness or unsettledness over lack of closure with their selected clients. Bob's process was complicated by negative supervision and system dynamics material. Matthew's process included questions related to questioning his clinical interventions and was eased by positive supervision, which assure him that he had delivered an acceptable level of client care. Eva and Susan expressed a discomfort with the lack of closure related to client-directed terminations dynamics.

Conflicted and/or in Pain Sub-Sub-Category

Sam and Beth both reported a great deal of turmoil following the termination of their selected client cases. Both of these participants reported significant negative

system influence on the outcome of the therapeutic relationship. The details of the systemic dynamics are more directly discussed within the system dynamics category.

Sam reported the aftermath/post-outcome reflection period following termination with Deb as one of significant stress. Several weeks after his termination with Deb, Sam was called to a meeting with the agency's clinical director. He reported this meeting event as follows:

> They interviewed me to find out the details of what had happened [with Deb and her reports of sexual contact with the other staff member]. It lasted probably an hour meeting with them. I asked my clinical director, "Should I consider resigning?" [He responded], "No. No. Why would you want to do that?" I said, "I have a feeling I violated agency reporting [policy]. I did report it, but I didn't do it in a timely fashion." He said, "no, you did not. You're supposed to report that immediately." And I said, "I reported to his supervisor." He said, "Yes, but when she didn't act on it, you needed to report it to [your supervisor] yourself." I was very anxious.

The story continued as Sam described a meeting that took place a short time later with the agency psychiatrist:

> Things didn't feel right after I met with [the clinical director], but then I met with [our agency] psychiatrist. He interviewed me and was asking me some very specific questions and very personal questions. How do I get along with my own wife? My sexual relationship with my wife? What did I think of Deb? Ah, did I believe what she had said during the summer about she and [the offending caseworker]? When she came into my session what kind of clothes was she wearing? Were they revealing? And, I just said right back to him, "I know what you are trying to get to. I'm a professional, I'm not an idiot." Those were my exact words. Then I said, "Do I need to get my lawyer involved? I don't like this." And she said, "No. We're just gathering information."

A month later the state sent an investigator to interview Sam and the "offending" staff member. Sam didn't hear anymore about Deb or the circumstances around her case for several months. During that time his supervisor resigned and he was assigned a new supervisor. Approximately six months after his termination with Deb, Sam's

new supervisor and his clinical director entered his office with a letter. Sam's spoke of his memory of this encounter and the events following as very life-impacting:

> They sat down and said, "we're going to be ending our working relationship with you. We're sorry to say but you're fired; you're discharged." I was heartbroken. They said they had found that there was a sexual relationship and that since I had neglected to inform my supervisor, I was just as guilty as [the offending caseworker] for not reporting it. I begged for my job, but I was discharged. I said, "does this need to be reported? I'll lose my license." They turned to each other and said, "No." I said, "It's not enough to report to the department of professional regulation but you're going to fire me?" They responded, "We need to." All they would say was, "we need to part. We need to separate ourselves from you because she could sue us." I transferred my clients, and I left. You know it was a job I really loved. I loved being an outpatient therapist and doing family, individual, and couples therapy. I felt like a real therapist. Had my own office. Wore my little Rogerian sweater - my cardigan -and it was over.

Sam's aftermath/post-outcome experience did not end with losing his job. Three years later he received a subpoena in regard to Deb's case. He said, "I can't tell you how many anxiety attacks I had about that. I was getting on with my life and then this. I got scared and very depressed." He called Deb's lawyer and was assured that he was only being called as a supporting witness and was not going to be sued. He continued to discuss this difficult period in his life and at times almost seemed to be talking to himself. It appeared he was going over old material and was once again trying to understand where he had been right and how he had been wrong:

> If this did go to trial, I knew I didn't want to have to think about it again. I attended a deposition where I was the only witness with three lawyers. They asked just a lot of questions about the situation and my character. At the end they asked "did you believe Deb about the sexual incidents with the agency caseworker or not?" Either way I should have reported it. I really, never knew what to believe. I just put it away and I didn't want to get into trouble. And thought that with my report to his supervisor I had covered myself to but there was something with not reporting to my own supervisor that I knew was not right. I felt it the whole summer. And that was what wound up getting me fired.

> That's the end of my ethical dilemma. It's affected my confidence in myself. I lost a job.

Beth's style of expression within the aftermath/post-outcome reflection sections of the interview tell a story of powerful emotional response. At one point in the interview Beth referred to this case and its outcome as the time when she lost her professional "virginity." Later in the interview Beth said, "I felt like I failed her and I still do. I feel like I failed her. I would handle all this much differently today." On five different occasions during discussion of her post-outcome experiences, Beth referenced her feelings of being scared in relation to Anne having threatened to kill her.

Beth said, "I remember being angry at times," and went on to describe one of the situations that generated the anger for her. She referenced the ethical dilemma she felt when the pastor who saw Anne in the same building where her agency housed her office repeatedly inquired about Beth's refusal to see Anne. For some time she felt she had to maintain confidentiality and would not inform him about the situation:

> I remember being especially angry over the confidentiality piece. You see, it was a terrible moral dilemma for me. After all, you can breach confidentiality if clients are at a risk of harm to self or others. How do we define others? Never thinking until it hit me one day – "other" meant me as well. So her being in the building a lot was putting me at some risk because she wasn't well at that time. This was right after [she threatened to kill me]. She was still actively psychotic. She was refusing medication. It took me a while to recognize how little support I had. They never had a counselor in that particular small-town office before, even though it was part of their contract. The reality of how human services works sometimes is just appalling.

During the face-to-face interview, nearly a decade after the events of this case, the anger and pain in Beth's aftermath words were very evident. At one point in the

interview Beth revisited her anger piece, stating, "I remember feeling pissed off." This piece of anger was directed at the instructor of her community agency class because she believed he didn't teach the class what they needed to know for the realities of professional life.

The conceptual maps for both Sam and Beth demonstrate their conflicted and/or in pain aftermath/post-outcome experience. As mentioned in the introduction to the aftermath/post-outcome reflection category, Sam's map (Figure 9) contains the content symbol that gave voice to the aftermath portion of the category's title. Sam did not label the oval to the right of center at the top of his map as he was creating the map. However, when discussing his map and describing this particular oval, he said, "I wanted to put this [here]. This was me at the end. Lack of confidence about getting a new job, getting on. The aftermath." It was as he discovered and spoke the word "aftermath" that he wrote out the new-found label for his oval *Aftermath* content symbol. As he wrote *Aftermath,* his non-verbal language changed from limp to crisp. The contrast was striking. Beth's map (Figure 15) is full of content symbol labels that reflect the emotion-laden reflections about her aftermath/post-outcome experience. These content symbol labels include *My emotions/Cognitions, My Ugly,* and *My system failures.* The *My Emotion/Cognitions* rounded square in the top right corner of Beth's map contains Post-it® notes that read *Scared, really painful for me,* and *lot of guilt/feeling like I failed/traumatic.*

Sam and Beth reported aftermath/post-outcome reflection processes characterized by pain and conflict. Both experienced system-directed terminations

under very difficult circumstances. At the time of the interview Sam was still very confused and conflicted about his interactions with Deb and the agency. Although Beth was very emotive about her work with Anne during the interview, she reported being able to use the situation to empower her as a client advocate.

Growth Realized Sub-Category

Although the Growth category contains data from only five participants, this is not to say other participants did not experience growth resulting from their experiences with selected client cases. Although a few participants were asked to comment on what they learned about their approach to case process after creating and reviewing their maps, no participant was directly asked to report on professional growth resulting from selected client case experiences. Additionally, this was a time-limited, semi-structured interview that took a brief snapshot of the participants' experiences. Consequently, it is conceivable that other participants did experience some professional growth resulting from their work with selected clients but did not happen to report this component during the face-to-face interview. The growth sub-category reports participant data gathered during the face-to-face interview relevant to clinical insights and professional growth specific to work they did with selected client cases. Some participants did verbalize insights regarding professional self, clinical work, and/or decision making in general when asked about their reaction to the CMT. This data will be presented within the participant reaction to the research tool category.

Bob, Matthew, and Daniella all reported professional insight and/or growth in the area of supervision. Bob spoke about how his negative supervision experience during his work with Jennifer informed his thinking as a supervisor. He reflected on his desire to be sensitive to the needs of his supervisees, thoughts on working to help them through struggles, and aspiration to help them grow through the hard cases. Matthew and Daniella both had positive supervision experience with their selected client cases. Matthew stated, "My self-esteem and confidence grew when I spoke to my supervisor." As Daniella reviewed the crisis that ended in hospitalizing Lucy and her supervisor's guidance, she said, "Things have changed for me [and I now understand] the importance of supervision and protocol. If I came across something like this again I would seek supervision right [away]."

Matthew, Eva, and Beth reported insight and/or growth in the area of professional self and identity. As Matthew looked back on his work with Franklin, he indicated he was still asking if he could have done more, but pointed out he was also coming to realize "one of [his] wrists was handcuffed" because Franklin didn't want change. He stated that working with Franklin was "a very awesome challenge – something to grow on." Eva completed the creation of her map, studied it, talked about it, and then said, "Well, I can see who did all the work. It was me." Later in the interview she explained more of what was behind this reaction:

> I think you have to learn whether you're the client or the therapist. Either way there has to be a lot of thinking going on. . . . I know I worked way too hard on this case. Beginners do. You know, I haven't been at this too long.

Beth's presentation about her items of growth and learning was passionate. She stated that her work with Anne "Changed how I viewed my job with clients and I gained a deeper understanding of the seriousness of mental illness." At another point in the interview Beth talked about how her post-outcome reflections on her work with Anne informed her understanding of the power inherent in her position as a professional and began to form in her a realization that "advocacy" is critical for her professional practice. Nearly a decade after her experience with Anne, the fact that these pieces have become a core part of her thinking and professional practice is peppered throughout the interview transcript.

Beth maintained that although she believed there was much she "should have known," she also acknowledged that she couldn't "know everything." However, she also believed that she "could have worked harder to try to advocate for [Anne] with [the system]. The following selected excerpts from Beth's transcript tell the story of her growth in the area of professional power taking and advocacy:

> I didn't feel victimized. I think in my naiveté and my lack of taking power I victimized her. Because, when I realized what was happening, I could have very easily advocated for her to get in-patient. But I didn't know [how] to do all that. I didn't know. I didn't know my power [back then], my training hadn't provided it for me. . . . We are dealing with serious health issues. I didn't get that [back then]. I just thought of myself as a therapist removed from that [*Beth's words trail off here*]. . . . I saw [this case] as losing my virginity because of how much [the case] impacted me. I'm no longer afraid to be a bitch or to be seen as a bitch to the system. I don't care. What's important is [cases like Anne's]. If that is my client now, I will be a bitch for them. I will do what needs to [be done]. I will advocate. Yes, advocate is the right word, especially with people who are powerless in the culture, people who are poor and mentally ill, and together that's a room full of them. They especially need really aggressive advocacy. I didn't know that then. We didn't talk about advocacy in my school.

The conceptual maps of all five participants who reported insight and/or growth gained through their work with the selected client cases have relevance to the data in this section. Bob (Figure 5) and Eva (Figure 14) both reported gaining insight while reviewing their maps. Matthew (Figure 6), Daniella (Figure 8), and Beth (Figure 15) created content symbols that denote their insight and/or growth areas.

Both Bob and Eva saw the CMT as a positive opportunity to reflect on the work they did with their selected client cases. As Bob was studying and describing his map, he shared,

> Actually I got to thinking about my supervision style because I've probably never put together this case with how my style of supervision is now. But I was thinking about that as I was talking about [the supervision content symbol]. I think my supervision [model] now is coming from [my reaction to] this experience. Realizing how much [my supervisees] need. I don't want to do it for them but give them the [tools].

It was while Eva was studying her map that she blurted out, "Well, I can see who did all the work. It was me." After that she was off and running, putting her new insight about her work with Ed together with her belief that for the counselor to expend a disproportionate amount of energy is good for neither counselor nor client.

Matthew, Daniella, and Beth each created one content symbol within their conceptual maps reflecting growth and/or insights derived from working with their respective selected client cases. Matthew placed a rectangle at the top right corner of his map labeled *Final Thoughts "As I Move Forward."* This content symbol contains a Post-it® note that reads *Awesome Challenge.* It was as he was describing this *Final Thoughts "As I Move Forward"* content symbol that he made the comment quoted earlier in this sub-sub-section, "It was an awesome challenge, something to grow on."

Daniella created a rounded rectangle that she placed in the bottom left corner of her map and labeled *Importance of Supervision.* This content symbol label illustrates her post-outcome reflection that supervision is important and in difficult situations should be sought right away. Beth placed her Post-it® notes about committing herself to being a "*client advocate*" and understanding counseling as a "*serious business*" in the oval content symbol on the right side of her map labeled, almost as a declaration, *My Resolution.*

Bob, Matthew, Daniella, Eva, and Beth all shared the characteristic of reporting a realization of professional growth as a result of their ethical decision-making processes related to selected clients. Bob, Matthew, and Daniella reported growth in the area of supervision. Bob was able to take a negative supervision experience and turn it into insights about what not to do as a supervisor. Matthew and Eva reported an enhanced sense of professional self as a result of positive supervision experiences. Daniella reported a deeper realization of the importance of supervision as a result of her positive supervision experience. Beth reported that her experience with Anne and the systems that surrounded the case literally propelled her into new understandings about the seriousness of her work and changed how she viewed her job.

Participant Reaction to the Research Tool Category

During phase four of the face-to-face interview, the protocol called for the researcher to ask, "Do you have any reactions to the conceptual mapping task that you

would like to share?" The responses to this question formed the participant reaction to the research tool category. Although this category, like the outcome category, may have been easy to anticipate, the data produced by the question was interesting and informing. All but one of the participants had positive responses to the exercise and a number of the participants had enthusiastic responses to the CMT. Many of the participants spontaneously enumerated the learning that had occurred for them during the process of the CMT exercise, but in some cases the researcher inquired with additional probing questions about what they learned in doing the exercise.

Marti was the one participant who did not have a completely positive reaction to the CMT. When asked if she had any reaction to the CMT, Marti said, "I don't like it. It doesn't allow me to do my process the way I would [ordinarily] do my process. I would do it in a written outline form and would take time to review it several times." However, when asked if she if she had learned anything about herself during the exercise, she said, "It confirmed some things." Marti was then asked to say more about what the exercise had confirmed and she explained, "I have my own framework for looking at and understanding behavior. [The exercise] confirmed [my way] doesn't work with every client and that I don't try and do more than I think I do well." Although Marti did not like the exercise, she did seem to find some value in it.

Sarah and Susan indicated the exercise had encouraged them to think about the process of therapy and/or decision making in new or fresh ways. Sarah said, "In my everyday life I am pretty linear so this was a challenge at first, but I found it very, very

useful. It was fun to do. I was forced to think." Susan also indicated that the exercise made her think about process. She said,

> I've been doing [counseling] for so long I don't think about the process; I just do it. My initial thing was "let's just follow chronological order, then it was like no. It falls out very differently." I've never done anything like this before. It was kind of fun. It made me think about the process. It's a good visual tool.

Several participants saw the exercise as a tool that generated reflection and/or insight. Matthew's response was, "I think it's awesome, great, insightful and a great model for deep reflection that one can use when there is a feeling of incompetence or sense of being [inexperienced]." Suzy simply stated, "This is really good. It's a nice reflection tool for seeing how Patrick's process is progressing." Sam, who presented as very conflicted about his role in the case he presented, said, "I guess it's like a way of seeing where my mind was at during the whole dilemma." Jim used his map to reflect on his own style of dealing with clinical situations. He spoke of his sense of being "methodical" and his realization he has "never been afraid of asking for help." Both of these reflections were said with an air of self-affirmation and contentment. He said,

> If I get a sense that something is wrong, I first try to figure out exactly what is wrong. I look at the problem. If I can identify the problem then more than likely, I can come up with a solution, but if not, it's time to get another opinion.

Eva said, "I enjoyed it. I found it very clarifying. It made sense and gave me some good insight and a lot of ideas to work on with a current client. It was very helpful."

A number of the participants spoke either spontaneously or upon inquiry about what they learned about themselves as they looked at their maps. Sarah indicated that although she didn't learn anything new about her approach to therapy or decision

making, the exercise ordered her thinking and informed her about how she goes about making ethical decisions in the context of clinical work. Bob credited the exercise with generating his awareness of the issues involved in discerning and dealing with boundaries of competence concerns. When Suzy was asked to reflect on what her map told her about herself, she said with an air of new-found confidence,

> I think I've done a good job working with Patrick and giving him the kindness and support that he really values. I don't want to give myself too much credit for his [progress], but I can see I'm dong my role.

Sally affirmed that it was interesting and went on to speak enthusiastically about the connections she was making because of the exercise.

Daniella, Sam, and Beth seemed to find some degree of closure for old cases that had not been settled for them. Daniella said, "It was good to remember." The researcher reflected to Daniella, "It sounds like, as you did this exercise, something inside of you said 'that's settled." Daniella's response to this reflection was "Yes. Yes, it is OK now." Sam came to the face-to-face interview ready to present this case and his continued conflict about it. At the conclusion of the interview Sam and I exited the building together. As we walked to our cars, Sam indicated that the CMT had given him a tool to process the case and then he asked if there was any other help he could access in settling his internal conflict around this case and its difficult consequences. He had found the tool helpful, but the matter was not completely settled for him. Beth indicated she had processed this case many times over the years since it had happened and yet, as she reflected on her map, she said, "I see it as losing my virginity. I see how much this has impacted me." Later she indicated that looking at her map helped

her realize she had come a long way in her professional life since those novice days and her work with Anne.

June and Bill appeared to use the CMT as a consultation that gave them direction for resolution to current cases. At the end of the exercise June reflected on her map and stated, "I am going to keep her, because it's my issue, not hers." She indicated that the exercise laid it out on paper for her and facilitated her decision-making process. Bill decided to keep working with Ray for the time being. His response when asked about his reaction to the CMT was, "It sort of reminded me of defragmenting my computer. I carry a lot of stuff around in my brain. It is really fun and helpful to sort it out. It's a relief and a release of energy. A lot of times I don't know what I know until someone asks me." Bill went on to indicate that the exercise energized him for continued work with the case, as it gave him a tool to order the clinical material.

The common characteristic of this category is participants' response to inquiry about their reaction to the research tool. Participants generally reported that the CMT was useful for reflection, insight, and/or learning. A number of the participants also stated they experienced the exercise as fun and/or enjoyable. There was an unanticipated positive energy present in most of the interviews that is somewhat captured in statements made by participants about their reaction to the CMT, but, additionally, there was an energy present that cannot be captured by words. There was a general attitude of gratefulness on the part of the participants about the opportunity to work through a case using the CMT.

Participant data have been presented in the five decision-making categories and the one category related to the conceptual mapping research tool. Participants described differing paths to resolution of their ethical dilemmas. The 14 paths differed from each other in many ways but were also similar on a number of levels. The similarities provide a general framework for viewing ethical decision making in relation to boundaries of competence for these 14 counselors. Five components of ethical decision-making emerged from the data gathered in the process of this study. The five components are the therapeutic relationship, supervision dynamics, system dynamics, outcome, and aftermath/post-outcome reflection. These five components are presented in Chapter 5 as decision-making categories. In Chapter 6 they are presented as the five components of a research-based model for ethical-decision making, which is referred to as the emergent model, and presented in conceptual map and discussion form.

CHAPTER 6

DISCUSSION AND IMPLICATIONS

The purpose of this qualitative grounded theory study was to explore ethical decision-making patterns reported by practicing professional counselors when encountering boundaries of competence concerns. Boundaries of competence and ethical decision making were the two focus points of this study. Fundamental to the ethical practice of professional counseling is the ability to make sound ethical decisions and understand competence boundaries (Corey, Corey, & Callanan, 2007; Kitchener, 2000; Remley & Herlihy, 2005; Welfel, 2006).

Competence is foundational to the life of mental health professionals and critical to the vitality of their professions (Haas & Malouf, 1995; Herlihy & Corey, 1996; Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Remley & Herlihy, 2005). It has been said that all sections of each of the ethics codes relate, at least to some degree, to issues of competency (Haas & Malouf). Boundaries of competence concerns often fall into the category of ethical dilemmas (Van Hoose & Kottler, 1988). According to Van Hoose and Kottler, therapists repeatedly find themselves working outside their area(s) of competence because every client brings distinctly different concerns and personal dynamics to the treatment process.

Straightforward or simple ethical decisions are part of everyday experience for professional counselors. Haas and Malouf (1995) reported that counselors take in an "enormous amount of information in the context of underlying 'operating principles'" (p. 7) on a daily basis and regularly make ethical choices almost without conscious thought. Whereas some situations are uncomplicated, and draw only on ordinary moral understandings developed in everyday life, the mental health professional also faces increasingly complex ethical difficulties (Kitchener, 1984b, 2000; Haas & Malouf, Welfel, 2006). Complex situations which have no obvious or simple answer are known as ethical dilemmas (Kitchener, 1984b; Remley & Herlihy, 2005; Welfel). For these complex situations counselors can turn to ethical decision-making models.

According to Neukrug, Lovell, and Parker (1996) and Hill (2004) ethical decision-making models are specific approaches to resolving ethical dilemmas requiring decision-making guidelines outside what professional codes of ethics are designed to address (Hill; Neukrug, et al., 1996). A number of ethical decision-making models were reviewed for this study (Betan, 1997; Cohen & Cohen, 1999; Corey et al., 2007; Cottone, 2001, 2004; Forester-Miller & Davis, 1996; Garcia, Cartwright, Winston, & Borzuchowska, 2003; Hansen & Goldberg, 1999; Hare, 1981; Haas & Malouf, 1995; Hill, Glaser & Harden, 1995; Koocher & Keith-Spiegel, 1998; Kitchener, 1984b, 2000; Mattison, 2000; Remley & Herlihy, 2005; Rest, 1984, 1994; Stadler, 1986; Tarvydas, 1998; Tymchuk, 1981; Welfel, 2006; Woody, 1990). These models contain some common components that have been listed and cross-referenced

in Chapter 2. The end result of this study is a research-based model for ethical decision making in relation to boundaries of competence situations.

The qualitative research design for this study was based in grounded theory methodology (Glaser & Strauss, 1967). The end result in grounded theory qualitative research is the emergence of theory, or in the case of this study, a research-based model for ethical decision making. The research tool used in this study was a four-phase, face-to-face interview based on the conceptual mapping task (CMT) interview model first reported by Martin, Slemon, Hiebert, Hallberg, and Cummings (1989) and later described in detail by Cummings, Hallberg, Martin, Slemon, and Hiebert (1990).

Counselors were invited to participate through a random selection process using licensure lists for the state of Illinois. Fourteen professional counselors who responded to the invitation were selected to participate in the four-phase, face-to-face interview. The first phase of the four phase interview was used for general demographic data collection. Phases two and three used the CMT format. The first three phases followed a structured qualitative interview pattern. The fourth phase was designed as a semi-structured qualitative interview. A detailed outline of each phase of the interview process can be found in Appendix D.

Phases two and three closely parallel the CMT described by Cummings et al. (1990). During phase two, participants were asked to select a client case in which they had felt "over their head." Following the selection of their boundaries of competence concern case, participants were asked to relate the story of their selected case situation from point of awareness of the boundaries of competence concern through resolution

of the concern. As each story was told, the researcher recorded it on small rectangular Post-it® notes. During phase three, participants were asked to create a conceptual map of their decision-making process. Creation of the conceptual map involved arranging the Post-it® notes into a visual representation of the relationships between the different concepts, drawing lines between closely related concepts, drawing circles around clusters of concepts, and then labeling the circled clusters.

Phase four was an unstructured phase in this otherwise structured interview process. In this phase participants were invited to make additional comments about their decision-making process and asked for observations concerning the conceptual mapping task. Additionally, this phase provided the researcher opportunity and "latitude to explore the responses of participants and to adapt question[s] for respondents" (Heppner, Kivlighan, & Wampold, 1999, p. 259).

Four research questions were proposed for this study. The first question was "what ethical decision-making model emerges from the data as the professional counselor outlines the process she or he follows to resolve a boundaries of competency concern?" The second and third questions requested a comparison of experienced and novice counselor ethical decision-making processes and implementation of their decisions for resolutions. The fourth question asked for a comparison of the ethical decision-making processes of participants with ethical decision-making models currently found in the literature. As reported in Chapter 5, questions two and three cannot be answered from the data collected for this study. Response to questions one and four form the core of this chapter.

The research-based model resulting from this study is referred to as the *emergent model*. The first section of this chapter presents an overview of the emergent ethical decision-making model. The second section is a comparison of the new research-based model with the ethical decision-making models and other relevant literature reviewed in Chapter 2. Expanded discussion of the rationale behind the encouragements and/or cautions for counselor educators, supervisors, and counselors, which emerged during analysis of the data, is presented in section three. The fourth section provides discussion related to the research tool used in this study. Following these sections, conclusions and implications for the profession and research will be offered in brief, bulleted statements.

PRESENTATION OF THE EMERGENT ETHICAL DECISION-MAKING MODEL

The emergent model for ethical decision-making is a research-based model specific to boundaries of competence concern situations. Because a search of the literature produced no ethical decision-making models based in field research, it is assumed that the emergent model is the first research-based model to be presented. Additionally, because no ethical decision-making models specifically designed for boundaries of competence concern situations were found in the literature, it is also assumed that the emergent model is the first ethical decision-making model to be developed and presented focusing specifically on boundaries of competence concerns.

The emergent model has an interactive non-linear directional movement, contains five components or major areas for consideration in ethical decision making,

and a number of dynamics that occur both within and between components. The model emerged during the analysis of both transcribed interview and participant conceptual map data. The five major areas for consideration in the emergent model correspond to the five ethical decision-making categories presented in Chapter 5. The five areas are: therapeutic relationship, supervision dynamics, system dynamics, outcome, and aftermath/post-outcome reflection. Each area contains primary, secondary, and/or tertiary elements that correspond to the sub, sub-sub, and sub-sub-sub-categories presented in Chapter 5.

Presentation of the model begins with a conceptual map. Discussion of the directional movement of the model follows the conceptual map. An overview of the five major areas of consideration and their elements concludes the presentation of the model.

Emergent Model Conceptual Map

Presentation of the emergent model conceptual map is found in Figure 22. Content symbols illustrating the five major areas for consideration are designated in the conceptual map with no shading. Content symbols representing elements are shaded. Primary element content symbols are designated by light shading. Secondary element content symbols are illustrated by darker shading. Tertiary elements are found only in the therapeutic relationship component and are illustrated by the darkest shading used on the map. The therapeutic relationship content symbol is marked out with thick lines. The thick boundary lines and the two levels of lesser content symbols

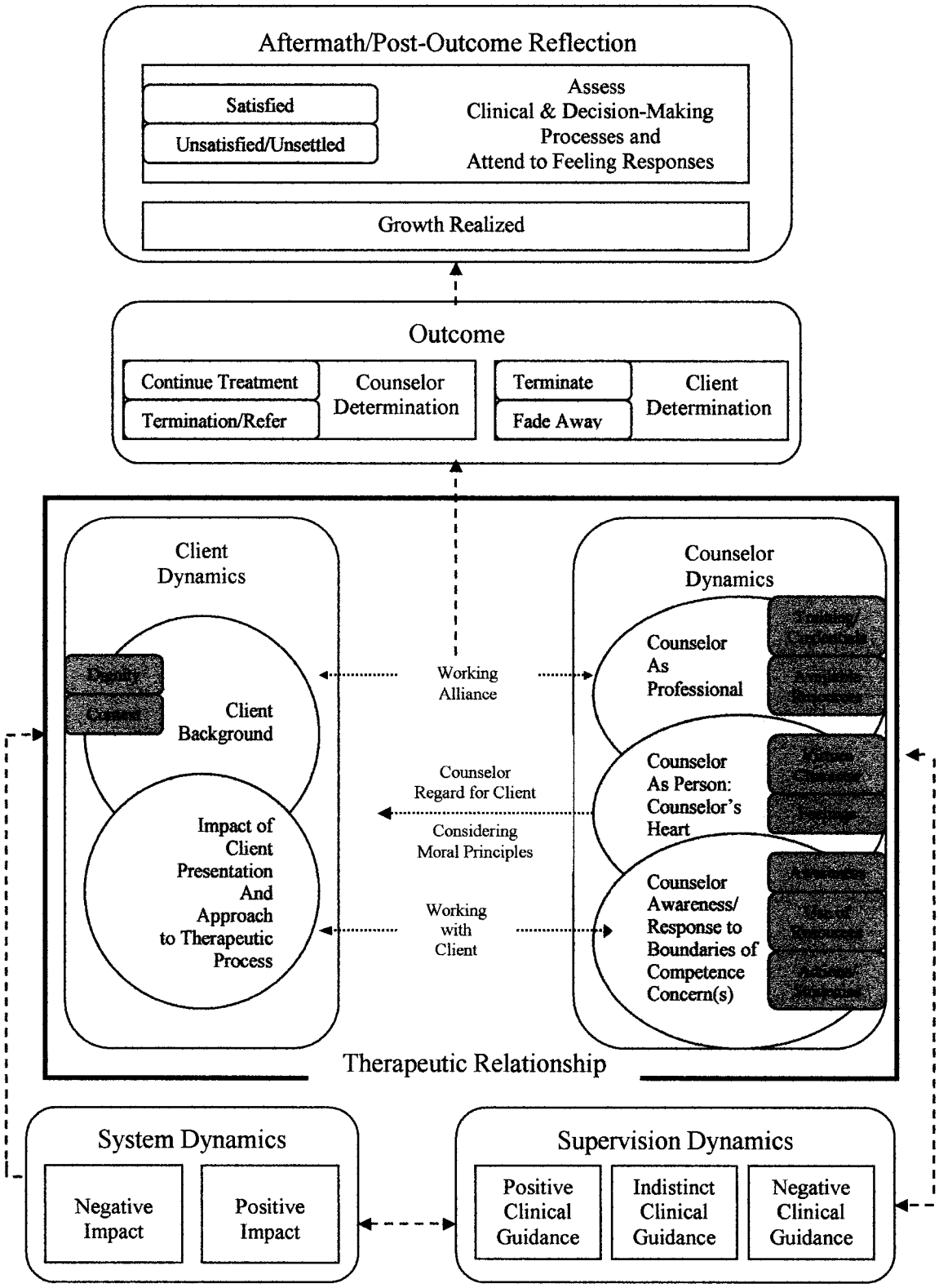


Figure 22. Emergent Ethical Decision-Making Model

on the conceptual map are intended to highlight the fact that this consideration, along with its elements, internal interactions, and inter-component connections, forms the core of the model.

The eight interactive and/or impact flow lines in Figure 22 indicate some specific dynamic within and/or between considerations. Two of the flow lines within the therapeutic relationship consideration are double-pointed arrow lines and illustrate the interactive nature of the relationship between client and counselor. The one single-point arrow signifies counselor regard for client. The double-pointed arrow flow line between the therapeutic relationship and supervision dynamics components illustrates the interactive nature of that relationship and also signifies participant-reported supervision impact on both therapeutic relationship and decision-making process. The single-point arrow line flowing from the system dynamics to the therapeutic relationship represents the potential impact system dynamics can have on client, counselor, clinical interactions, and the decision-making process. The double-pointed arrow flow line moving between system and supervision dynamics illustrates the interactive nature and impact of the dynamics between these two areas on the decision-making process. The single-point arrow flow line pointing upward from the therapeutic relationship to the outcome area gathers all of the other flow lines that impact the decision-making process and illustrates the flow of the process as a decision for resolution is worked out. The final flow line moves from outcome to aftermath/post-outcome reflection and is about the potential impact decision-making processes in complex situations can have on counselors.

Throughout the discussion of the emergent model the terms "ethical decision-making process" and "decision-making process" are used frequently. Participants were asked to begin their stories at the point they first became aware of their limits to treat and continue through the process of continued treatment, termination, and/or referral. However, participants began their stories with the therapeutic relationship and continued through the aftermath/post-outcome reflection process. Participants included all of the elements from therapeutic relationship as a start point to aftermath/post-outcome reflection as an end point in their understanding of the decision-making process. Therefore, these terms are intended as an overarching reference to participant stories from start to finish, and are inclusive of the entire process illustrated in Figure 22.

Decision-Making Process Style: Interactive Non-Linear

The emergent model for ethical decision making is interactive and non-linear. All participants told stories and created maps about ethical decision-making processes that were interactive. Although several participant maps look linear at first glance, all of them are interactive. Only one participant actually presented a decision-making process that was linear, but even that participant talked of the interactive nature of the decision-making process that took place between his supervisor and him. The terms *interactive* and *non-linear* are intended to convey two core concepts upon which the emergent model is based.

The process is interactive at two levels. The first is between participant and other parties involved in the process (e.g. clients, supervisors, systems). The second involves internally interactive thinking and feeling processes. Participants demonstrated that external interactions are sometimes between counselor and client, often between counselor and supervisor, and occasionally between counselor and the system or systems in which the decision-making process is embedded. Participants repeatedly reported their own thinking and feeling processes as being a series of internal interactions generated and/or impacted by unfolding client stories, supervisor information or actions, and system dynamics. Additionally, participants reported the internal thinking and feeling process as being informed by professional knowledge gained in master's-level academic training and continuing education experiences.

Non-linear indicates that decision-making processes do not proceed neatly from one step to the next, from beginning of awareness to resolution and is, thus, non-linear. Each participant told of a process involving most, if not all, of the components found in the emergent model. All participants shared experiences of moving back and forth between various components and internal dialogue until resolution was reached.

Although the process is not linear, it does have a start and end point. The start point for all participants was contained within the therapeutic relationship. The end point was housed in the aftermath/post-outcome reflection area of consideration.

Therapeutic Relationship Area of Consideration

In this study, therapeutic relationship was defined as the interactive bond between client and counselor that has "specific tasks and goals to accomplish to help clients resolve problems" (Hill & O'Brian, p. 35). The 14 participants did not speak of the therapeutic relationship as a sterile clinical commodity. Their stories of ethical decision making around boundaries of competence concerns were told from a professional perspective infused with a sense of personal care. Participants presented stories, which said that the process start point was the therapeutic relationship, and the model reflects this.

The core of the emergent model is the therapeutic relationship. It is the core because of frequency of occurrence in the data and prevalence of other component dynamics flowing in and/or out of the therapeutic relationship component. According to Dick (2002), this frequency of occurrence in the data and linkage to other categories is what defines core categories in grounded-theory research. Thus, the core category described in Chapter 5 as the therapeutic relationship category becomes the core of the emergent model.

The therapeutic relationship as a major area of consideration in ethical decision making emerged from participant data about the relationship between themselves and their selected clients. These data involved dynamics that both counselor and client brought to the therapeutic relationship and the manner in which each played out her or his role within the treatment and decision-making processes. There are two primary elements within this category. First is the client dynamics element containing two

secondary and two tertiary elements. The second primary element is counselor dynamics, which has three secondary and seven tertiary elements. Primary, secondary, and tertiary elements of the therapeutic relationship component are illustrated in Figure 22.

As the core component, the therapeutic relationship contains and is impacted by more flow lines than any of the other components. Flow lines between counselor and client demonstrate interactive dimensions of the therapeutic relationship as well as the consideration and regard extended to clients by the counselors. These interactive dimensions are discussed within the counselor awareness of and response to boundaries of competence concern(s), the secondary element of the counselor dynamics primary element. Flow lines between the therapeutic relationship component and the supervision dynamics, system dynamics, and outcome areas of consideration are addressed within each of these other areas.

Client Dynamics Primary Element

Client dynamics within the therapeutic relationship were woven into each participant's story of ethical decision making. As participants related their selected client case decision-making processes, all included information about their general understanding of client life context, including background and stated presenting concerns. Participants also spoke of their perceptions about the client's approach to the counseling process. The client dynamics primary element contains two secondary

elements, (a) client background and (b) client presentation and approach to the therapeutic process.

Client Background Secondary Element

Every participant began his or her story with background data on their selected client and all participants included at least one content symbol about client background on their conceptual maps. This is interesting in light of the instructions requesting participants to begin their client story at the point they became aware of a boundaries of competence concern. It could be argued that it is common practice for all mental health professionals to present some background information when explaining client cases and therefore this is not a significant finding. However, what was striking in the analysis of these data was how participants consistently pointed out the background circumstances surrounding client difficulties and/or the life circumstances in which the client was managing her or his concerns. These reports of client background and circumstances were not just introductory remarks to orient the researcher. Participants wove background and context pieces throughout their stories of ethical decision making and reported these as important aspects of the entire decision-making process.

Client background is an important consideration in the emergent model. There are two characteristics common to and significant about the client background primary element. These characteristics are: (a) the inclusion of client background and/or context in the entire ethical decision-making process, and (b) the compassionate or

humane manner in which counselors present the contextual information. More discussion about the dynamics and importance of considering client background is offered in the discussion section of this chapter.

Human dignity tertiary element. Additionally, the manner or tone in which participants delivered background and context information is significant. The human dignity tertiary element is shown on Figure 22 as a darkly shaded rounded rectangle labeled *dignity.* Participants presented background information about clients with a noticeable sense of "humanness" in their descriptions. Generally, there was a distinct graciousness to the manner in which participants explained their clients' circumstances and struggles. They did not recite the generally accepted clinical data in a sterile fashion. There was life and story evident as participants introduced their clients as people who had a context out of which their stories and concerns emerged.

Contextual sensitivity tertiary element. In the emergent model, context includes consideration of "age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, and socioeconomic status" (ACA, 1995, Section A2a.). Multicultural competence is important to the counseling profession (Remley & Herlihy, 2005). Consideration of client context factor in the emergent model leaves generous space for, and even invites, counselors to attend to multicultural dynamics and to integrate those considerations at all points of the decision-making process. In the emergent model, multicultural sensitivity is included under the general rubric of contextual sensitivity, which includes consideration of client context, protecting the dignity of all clients, and attending to the potential for differing values between client

and counselor. The contextual sensitivity tertiary element is shown on Figure 22 as a darkly shaded rounded rectangle labeled *context.*

Participants reported only two noticeably multicultural situations. One client struggled with age differential and another was empowered to advocate for the poor because of what she experienced in working with her selected client. Because of the emphasis on consideration of client background as well as client presentation and approach to the therapeutic process, this model is applicable to multicultural situations and when used by counselors who are multiculturally competent, the emergent model provides guidance that can enhance multicultural sensitivity.

Impact of Client Presentation/Approach to Therapeutic Process Secondary Element

It is natural to assume clients have a role in the therapy process and outcome. It was not anticipated that client presentation and approach to the therapeutic process would be a factor in the ethical decision-making process. However, the data collected for this study clearly indicated that the manner in which clients present in treatment as well as their approach to the therapeutic process can precipitate an awareness of a boundaries of competence concern and, additionally, may impact the ethical decision-making process.

Participants indicated that client presentation and/or approach to treatment had an effect on their decision making-processes from the point of awareness of the boundaries of competence concern through the outcome and aftermath/post-outcome. The data indicated that a client's presentation as silent, non-verbal, seductive, etc. can

alert counselors concerning their limits and subsequent need to attend to practice limits. Additionally, the data revealed that client response to treatment and/or general interaction style can influence the decision-making process. Client resistance or active participation factored into the decision-making processes for several participants. Some client presentations and approaches to treatment were seen as difficult and/or negative. Some client presentations and approaches were reported as positive and energetic. Regardless of the type of client presentation and/or approach, both affected decision making. Client presentation and approach to treatment is a factor counselors are encouraged to attend to in the emergent model. Further discussion about the inclusion of this factor in the model is offered in the discussion section of this chapter.

Counselor Dynamics Primary Element

As participants told their stories, created their maps, and then explained them, it became clear that all brought a sense of themselves to the decision-making process. It was this sense of self, both professionally and personally, that acted to form the therapeutic alliance and make decisions throughout the process. The counselor dynamics primary element within the therapeutic relationship component addresses the influence of the counselor as an active agent in the ethical decision-making process. The counselor dynamics primary element is made up of three secondary elements; (a) counselor as professional, (b) counselor as person: the counselor's heart, and (c) counselor awareness of and response to boundaries of competence concern(s).

Counselor as Professional Secondary Element

This secondary element addresses the formation and development of the professional self participants reported as informing and influencing their decision-making processes. Basic training, credentials, and utilization of available professional resources are all measurable parts of the development and professional identity of the counselor as professional. Training/credentials and available resources are the two tertiary elements within the counselor as professional secondary element. These tertiary elements are shown in Figure 22 as training/credentials and available resources.

Formal master's-degree training, professional licensure, and certifications make up the training/credentials tertiary element in the emergent model. Participants were all licensed counselors in the state of Illinois, which requires completion of a master's degree from a counseling or related program, and participation in continuing education activities. Therefore all of the participants had at least a master's degree, most held certifications in addition to licensure, and all reported involvement in continuing education activities. Graduate training and licensure, however, are only the beginning building block of professional formation and identity.

Counselors have a number of resources they can use for assistance with professional development and decision making in difficult situations. These resources, which make up the tertiary element, include an abundance of literature, professional codes of ethics, various services provided by professional organizations, and continuing education opportunities including workshops, seminars, and post-master's

coursework. Because supervision and/or consultation are also seen as contributing to professional development, they are sometimes spoken of in the context of continuing education (Corey, Corey, & Callanan, 2003). However, because participants generated considerable data related to supervision, these data formed a separate area for consideration in decision-making and are not included in this element. How participants used these resources is presented in the *response to concern* section of the *counselor awareness of and response to boundaries of competence* secondary element.

Professional self was presented as a factor in the decision-making process for participants in this study. Completion of a master's degree, being licensed, and utilization of professional resources were all part of the professional presentation of participants. Participants referenced their master's training as part of what informed their awareness of professional limits and decision-making processes. They also enumerated a vast amount of involvement in continuing education endeavors including independent reading, workshops, seminars, and post-master's academic endeavors.

Participants spoke of themselves in the decision-making process with a consciousness of the training foundations upon which their role in the therapeutic relationship and decision-making process rested. Each also brought to her or his role and processes an awareness of their own continuing professional development. This element in the emergent model honors the presentations of participants and serves as a reminder for counselors to have a firm awareness of their own professional foundations and development.

Counselor as Person: The Counselor's Heart Secondary Element

Requirements for obtaining and maintaining licensure as a professional counselor are externally measurable components. Underneath and woven through quantifiable licensure requirements is the person who holds the license (Remley & Herlihy, 2005). Participants revealed a sense of themselves as "persons" interacting in the process. During the course of data analysis it became clear that counselor character and emotional response influenced and, in some instances, determined the course and outcome or the ethical decision-making process. Presentation of the counselor as person factor in the ethical decision-making process is divided into two tertiary elements; (a) virtue ethics: counselor character and (b) counselor's feeling responses.

Virtue ethics: Counselor character tertiary element. Awareness of virtue ethics, the ability to self-identify virtue strengths and weaknesses, and the fortitude to demonstrate virtue in the face of difficult decisions are fundamental factors encouraged in the emergent model for ethical decision making. Virtue ethics are about counselor character. How participants did or didn't demonstrate virtue ethics forms the basis of understanding counselor character in this model. The five most commonly agreed-upon virtues for counselors are prudence, integrity, respectfulness, trustworthiness, and compassion (Corey et al., 2007; Kitchener, 2000; Remley & Herlihy, 2005).

Not all five virtues were demonstrated by all participants, but it was clear that the character of participants was woven throughout their ethical decision-making processes. Because one of the participants demonstrated only two of the five virtues,

his status as a virtuous therapist, based on this particular interview exercise, can be called into question. All of the remaining participants presented themselves as virtuous therapists. Analysis of the data shows that virtue has served these therapists well in identifying their boundaries of competence, regarding clients' circumstances with compassion, demonstrating practical wisdom in moving through the selection of options for resolution, implementing their decisions, and/or processing their cases after implementation of the decisions. The one individual whose status as a virtuous therapist is questionable had significant difficulties moving through his decision-making process and experienced a very painful aftermath/post-outcome reflection process. These participants demonstrated that counselor virtue impacted the ethical decision-making process whether character helped or hindered.

Impact of counselor feeling responses on the decision-making process tertiary element. From the first to the last interview conducted for this study it was apparent and even striking that these participants are human beings engaged in relationships. The relationships participants described were clinical, and yet, somehow involved a distinctly human and interpersonal exchange of feelings and reactions. As participants discussed the ethical decision-making processes they described and the clients with whom they worked, they told their stories with feeling and a genuine passion that only comes from the human heart. The presence of professional reaction, balanced with genuine person-to-person emotion, is evident throughout participant stories of ethical decision making. The non-verbal communications, interview spoken words transcribed into written words, and participant maps all contain the common

characteristic of feeling responses to clinical interactions experienced in the ethical decision-making stories of the counselors who participated in this study.

Participant feeling responses demonstrated a wide range of emotions and concerns. A number of participants spoke of and/or demonstrated a notable energy, enthusiasm, and even passion for their professional work. Participants expressed joy and satisfaction related to client progress. Feelings of deep concern, sadness, and anger at outside forces were expressed as participants related client difficulties. Confusion, feelings of being lost, and a sense of being overwhelmed were reported by some participants as they described client, supervision, and system dynamics.

Counselor emotions played a role in the clinical interactions and ethical decision-making processes of participants, but none of the participants indicated an awareness of the impact these feelings had on the process. Consequently, the data seems to indicate that alerting counselors to this factor is significant. Understanding about the use of emotion in the decision-making process is informed by both the research findings of this study and the literature. Further discussion about this factor is presented in the literature comparison and discussion sections of this chapter.

Awareness of and Response to Concerns Secondary Element

When participants were asked to tell the story of their journey with selected clients, the interview directions were designed to emphasize participant decision-making patterns. Participants selected a wide range of client presentations and clinical situations. Discussion of decision-making factors related to counselor awareness of

and response to boundaries of competence concern(s) is broken into two sections. The first deals with how participants became aware of and identified their concern(s). The second deals with the manner in which participants responded to their reported boundaries of competence concerns.

Awareness of boundaries of competence issue(s) tertiary element. An anticipated and obvious step in the decision-making process is the identification of the concern(s). As participants moved through the stories of their ethical decision-making process, they identified their boundaries of competence concerns with varying degrees of preciseness.

Participants reported coming to awareness of their boundaries of competence under a variety of circumstances and at varying times in their therapeutic relationships. The identified boundaries of competence concerns included a wide range of client issues and counselor concerns. Identification of concern is a factor in the emergent model. Realizing that identification ranges from a point-in-time realization to a slow and subtle process of growing awareness is fundamental to a complete understanding of this factor. Brief discussion of these varied modes of identification of concern(s) is offered in the literature comparison and discussion sections of this chapter. The awareness of boundaries of competence issue(s) tertiary element is shown in Figure 22 as a darkly shaded rounded rectangle labeled *Awareness.*

Response to concerns: Utilization of professional resources and actions/strategies tertiary elements. As they talked through their decision-making processes, participants described the various responses, strategies, actions, and

rationales they developed and/or implemented in response to their boundaries of competence concern(s). Participant responses to boundaries of competence concerns included seeking clinical guidance, utilization of professional resources, selecting and implementing actions, considering and/or working out of the therapeutic alliance, considering the client and applying moral principles, working with the client to reach resolution, interacting with the system(s) in which the client case was embedded, and selection and implementation of an action plan that would lead to resolution. These various counselor responses occur throughout the entire ethical decision-making process.

Counselor response factors, other than utilization of professional resources and selection of action plans, are discussed in other sections of the model presentation. Considering and/or working out of the therapeutic alliance, regarding the client by applying moral principles, and working with the client to reach resolution are all presented in the therapeutic relationship interactive flow lines sections of the therapeutic relationship area of consideration. Seeking clinical guidance and interacting with system(s) can be found under the supervision or system dynamics areas of consideration, respectively. Implementation of an action plan leading to resolution is part of the flow line (illustrated in Figure 22) moving out of the therapeutic relationship into outcome. A detailed discussion of the various response strategies, actions, and rationales presented by participants is offered throughout Chapter 5.

Only utilization of professional resources and counselor actions and strategies are presented and discussed under the counselor response to concerns section of the counselor awareness and responses to boundaries of competence concern(s) secondary element. These are represented in Figure 22 as darkly shaded rounded rectangles labeled *Use of Resources* and *Actions/Strategies.* Although participants reported involvement in numerous continuing education training opportunities, held memberships in a variety of professional organizations, and had ethics training, which presumably exposed them to professional ethics codes, there is little data in their transcripts to indicate they turned to these resources in resolving the particular concerns they reported. In spite of this paucity, the emergent model includes use of these resources in decision making, in part because their general absence is a clear statement of needed caution for the profession, and in part because of the dominance of this element in the literature on ethical decision making. Selection of an action plan was part of most participant plans. Some were clear and decisive about their action for resolution, some meandered until they or their clients found resolution, some had plans but the plans did not go as anticipated or desired, and some had plans imposed on them by the systems in which the cases were embedded. Further discussion of utilization of professional resources and action steps as factors for consideration in ethical decision making is offered in the literature and discussion sections of this chapter.

Therapeutic Relationship Interactive Flow Lines

The therapeutic relationship area of consideration has three internal and two external flow lines, as shown in Figure 22. Internal flow lines labeled *Working Alliance, Counselor Regard for Client,* and *Working with the Client* represent relational dynamics between counselor and client, which were part of the reported ethical decision-making processes of participants. Discussion of these three interactive flow lines begins with data related to the working alliance, continues with participant regard for clients, and concludes with participants' description of how they worked with clients to reach resolution. The flow lines connecting supervision and system dynamics to the therapeutic relationship illustrate both interaction and impact. These two flow lines are discussed under the supervision and system dynamics areas of consideration.

Working Alliance

The working alliance or developing, considering and/or working out of the strength of the therapeutic relationship was a factor in participant-reported process of ethical decision making. This factor is illustrated in Figure 22 as a double-pointed arrow line labeled *Working Alliance.* This particular double-pointed flow line illustrates a foundational piece of the decision-making process in this model. The existence or absence of a working alliance significantly impacts the process of decision-making, and thus, it is necessary for counselors to have an awareness of the

role of the working alliance. The dynamics precipitated by both the existence and the absence of a working alliance will be discussed later in this chapter.

Counselor Regard for Client: Considering Moral Principles

Regard for the client was an integral part of participant selection and implementation of actions in response to their concerns. Participants reported giving consideration to clients' circumstances, needs, and wants in developing, selecting, and implementing actions relative to boundaries of competence concerns. The manner in which participants spoke of or demonstrated regard for their clients parallels discussions of moral principles found in ethics literature. Thus the presentation of regard for the client as an ethical decision-making factor is structured around the five moral principles historically found in ethics literature (Beauchamp & Childress, 2001; Corey et al., 2007; Forester-Miller & Davis, 1996; Hansen & Goldberg, 1999; Jordan & Meara, 1990; Kitchener, 1984b, 2000; Meara, Schmidt, & Day, 1996; Remley & Herlihy, 2005; Van Hoose, 1986; Welfel, 2002). These five moral principles are autonomy, nonmaleficence, beneficence, justice, and fidelity. Regard for client autonomy, concern not to do harm, desire to do good, an attitude of fairness, and commitment to client welfare and dignity including truthfulness within the therapeutic relationship were reported by various participants during the interviewing process. Discussion of the manner in which participants presented client background and context material is found in the client dynamics primary element and clearly demonstrates participant regard for client dignity.

More detail about regard for the client as a factor in ethical decision making and moral principles as a framework for extending regard to clients is found in the literature comparison and discussion sections of this chapter. This factor is illustrated in Figure 22 as a single-pointed arrow line labeled *Counselor Regard for Client*. This line is intended to symbolize the counselor's understanding of the client and then extending to him or her all of the regard encapsulated within the moral principles as set out by the counseling profession.

Working with the Client

Working with the client is the final factor for consideration in this counselor response to concerns counselor dynamics primary element. This factor involves counselors working with clients to reach resolution for the identified concern. Whereas the working alliance is part of the general clinical relationship and its presence or absence can impact the decision-making process, working with the client to reach resolution is specific to the decision-making process and related to a specific concern or set of concerns. Data collected for this study demonstrated: (a) counselors successfully working with clients toward resolution of concern, (b) counselor attempts to share concern(s) resulting in clients being unwilling to work with them on the identified concerns and/or taking control of the process by implementing termination on their own terms, and (c) counselors selecting not to work with clients around their concerns. These differing decisions and results combined with guidelines found in ethical decision-making literature guided the decision to include working with the

client as a factor in the emergent model. Rationales for these differing approaches to identified boundaries of competence concerns will be discussed later in this chapter.

The therapeutic relationship, with its many and varied dynamics, is the most complex area of consideration in the emergent model. It is also the emergent model's core component. This component includes both counselor and client dynamics primary elements. Client dynamics include consideration of client background, context, presentation in treatment, and approach to the therapeutic process. Counselor dynamics include: (a) development of a professional self and credentials, (b) personal character and feeling responses to clients and their concerns, and (c) awareness and identification of boundaries of competence along with the counselor responses to concerns. These responses include interventions, strategies, and rationale for addressing identified concerns. Counselor response to identified concerns also involves developing a working alliance, extending regard to the client based on established professional moral principles, and deciding whether or not to work with the client for resolution. All of these decision-making factors are points of consideration in the emergent model for ethical decision-making.

Supervision Dynamics Area of Consideration

The importance of supervision in the ethical decision-making process emerged early in the interviewing process as participants described negative, indistinct, and positive supervision experiences. Supervision dynamics considerations and related primary elements emerged out of participant data related to clinical guidance

experiences during the course of working with selected client cases. Interview and conceptual mapping data related to formal individual supervision and consultation, supervisor-led supervision groups, peer groups, and networking contributed to the formation of this component. In the emergent model, supervision or clinical guidance is seen as potentially having an important impact on the counselor, client, therapeutic relationship outcome, and even the aftermath/post-outcome reflection.

Positive, Indistinct, and Negative Primary Elements

Key words describing supervision in the ethical decision-making process formed the three elements in this area of consideration. The three elements are positive clinical guidance, indistinct clinical guidance, and negative clinical guidance, which are illustrated in Figure 22. Positive descriptors included affirmation, empowerment, support, professional growth, meticulous oversight, challenge, and instruction. Imprecise, blurry, dim, faint, and vague are the descriptors that emerged to form the indistinct supervision grouping. The negative supervision grouping formed around the participant description of chaos, disruption, confusion, and contradictions.

Supervision dynamics data presented in Chapter 5 and illustrated in Figure 18 included a fourth supervision option, which was to seek no clinical guidance. Only one participant, Jane, reported seeking no formal or informal clinical guidance in working with her selected client. However, as Jane proceeded through the interview, it appeared that she was using the research interview conceptual mapping exercise as a consultation opportunity. Therefore, it was felt that including a *no clinical guidance*

element in the emergent model supervision component would not be a completely valid reflection of the data. Additionally, ethics literature clearly indicates, and sound clinical common sense would suggest, that in the face of an ethical dilemma *no clinical guidance* is not a viable option.

Supervision and the potential dynamics resulting from supervision interactions are a significant part of the emergent model. At both the negative or positive ends of the continuum, the data collected for this study clearly demonstrate that clinical guidance can skew the decision-making process, impact both counselor and client by influencing outcome, and affect aftermath/post-outcome reflection dynamics. In the middle of the continuum are the indistinct clinical guidance experiences shared by participants, and they, as might be expected, were reported as having little or no influence or impact on the decision-making process or parties involved. The little or no influence is in itself a significant clinical statement because imprecise, blurry, dim, faint, and/or vague supervision may not lead to the most clinically solid outcomes. The impact of supervision by type of experience is discussed further in the literature comparison and discussion sections of this chapter.

Supervision Dynamics Interactive, Influence, and Impact Flow Lines

In the emergent model, there are two flow lines directly related to supervision dynamics. One is a double-pointed arrow indicating both an interactive flow between supervision and the therapeutic relationship and the fact that supervision can have an impact on the overall decision-making process. The second is a double-pointed arrow

line moving between system and supervision dynamics. The second line demonstrates the potential intermingling of dynamics that can impact the decision-making process. This flow line is discussed within the system dynamics area of consideration.

The various experiences of clinical guidance (e.g. positive, indistinct, or negative) yielded varying interactive experiences between counselor and supervisor. The positive clinical guidance experiences involved a frequent and consistent interaction between counselor and supervisor. These participants consulted supervisors and received guidance that impacted the entire decision-making process as well as counselor sense of self in positive ways. Indistinct supervision was not referenced by participants as either helpful or disruptive. Negative clinical guidance experiences were very interactive and significantly impacted decision-making processes and counselor sense of self in a negative direction. Further discussion about the impact of the three types of supervision on the ethical decision-making process is offered in the discussion sections of this chapter.

In the emergent model, resolving an ethical dilemma without seeking clinical guidance is seen as a non-option. The format of the particular guidance may range from formal individual supervision or consultation to group or one-on-one networking with a colleague. Formal supervisor-led group supervision is also an option for finding clinical guidance when facing an ethical dilemma. Evaluation of the impact supervision is having on the decision-making process is an important part of the supervision component in the emergent model. Evaluating the impact supervision is having on counselor sense of self is also a part of this model.

System Dynamics Area of Consideration

The potential importance and impact of system dynamics in the ethical decision-making process first emerged as significant during the third interview conducted for this study. Then, almost with a vengeance, the theme stood out again during the seventh interview. Finally, in the thirteenth interview, the participant's impassioned account of her case, which was impacted by multiple social service agencies, told of the power she believed systems had exerted on her clinical relationship and decision-making process. These three dramatic systems scenarios raised an awareness of the potentially significant interface between system dynamics and ethical decision making. Consequently, all of the transcripts were analyzed for system dynamics data. The systems dynamic area of consideration and its elements emerged out of that analysis.

Although not all boundaries of competence concerns ethical decision-making processes are affected by system dynamics, the emergent model highlights the need for counselors to be aware of the potential role negative and/or positive system dynamics can play in the decision-making process. In this study a system is defined as any structured organization (e.g. agency or institution) established to provide social services and/or counseling to clients. System dynamics refers to the overt and covert interactions between individuals or groups of individuals within a system and/or between two or more systems.

The two primary elements of the system dynamics area of consideration are illustrated in Figure 22. The first element addresses negative system dynamics and the

consequent negative impact on the decision-making process. The second reflects participants' reported client cases situated in agencies, which they presented as having either a positive or neutral impact on the decision-making process.

Negative and Positive Impact Primary Elements

The primary elements making up the system dynamics component represent two ends of a continuum. Negative systems are defined as chaotic, disruptive, and experienced as disrespectful by one or more parties involved in delivering or receiving mental health services. A positive system is defined as supportive, ordered, facilitating, responsive, and considerate of all parties involved in the delivery of mental health services. Positive systems also provide resources needed for counselors to work at their clinical and ethical best with each client case.

In Chapter 5, the presentation of system dramatics data were divided into (a) negative impact and (b) positive or neutral impact sub-categories. The emergent model does not include consideration of the impact of neutral system dynamics. In Chapter 5 "neutral" referred to participant-selected client case stories in which counselors experienced system dynamics as impacting the clinical and/or ethical decision-making processes in neither negative nor positive ways. This essential lack of impact suggests that the neutral aspect of system dynamics is not a necessary part of an ethical decision-making model. Its presence in the model would not enhance any needed counselor awareness of the process. Thus, the emergent model encourages counselors to assess system dynamics' impact on the decision-making process by evaluating for

potential negative or positive impact. More discussion is offered on the importance of this step in the decision-making process later in this chapter.

Three participants reported experiencing system dynamics as having a negative impact on their decision-making processes. The overarching words describing their systems dynamics data are unresponsive, disruptive, chaotic, confusing, and disrespectful. These three participants told stories about system dynamics negatively affecting outcome for their clients and/or themselves. In each of these client cases participants made it clear they believed negative system dynamics were disruptive to the therapeutic process and either dictated or heavily influenced outcome.

Participants who indicated experiencing positive system dynamics reported the systems in which their selected client case was embedded as supportive, ordered, facilitating, responsive, and considerate. Because data collected for this study closely links positive system dynamics to positive supervision dynamics, providing and/or facilitating qualified supervision is considered a key indicator of positive system dynamics. Participant data contributing to the formation of this primary element did not necessarily explicitly declare the system from which their story emerged as "good" or "positive." In contrast to the robust participant voices of the negative impact primary element, data that formed this primary element, with the exception of loud declarations about positive supervision, came more from a position of silence. The absence of system dynamics creating difficulties in client treatment and ethical decision-making processes distinguishes positive system dynamics from negative system dynamics. In the emergent model the absence of difficulties alone is seen as a

neutral system. It is the provision of resources (e.g. good supervision, workshop training opportunities, etc.) and the respect for all parties in the process, in addition to the absence of negative dynamics, that truly distinguishes the positive system.

System Dynamics Interactive, Influence, and Impact Flow Lines

Two flow lines connect the system dynamics component to the interactive flow of decision making in the emergent model. The first is a double-pointed arrow line flowing from system dynamics to supervision dynamics. The second is the single-point arrow line flowing from system dynamics to the therapeutic relationship.

The impact of system dynamics on supervision dynamics most directly emerged from two of the three stories of negative system dynamics. These two participants reported the intermingling of complex system dynamics and supervisor relationships that led to a negative impact on counselors, clients, and the therapeutic relationships. The flow and impact between supervisor and system dynamics within positive systems was reported by participants as either facilitative or non-disruptive.

The impact of system dynamics on the therapeutic relationship was demonstrated in the data on a number of levels. Negative system dynamics were reported as negatively influencing the dynamics of the therapeutic relationships, adversely impacting outcome for both clients and counselors, and contributing to difficult, if not painful, aftermath/post-outcome reflections processes. Positive system dynamics impacted the therapeutic relationship by creating supportive, ordered, facilitating, and responsive environments that were considerate of all parties involved in the delivery

of services. These characteristics enabled counselors to work within the therapeutic relationship at their clinical and ethical best to resolve their boundaries of competence dilemmas.

The potential for systems to impact all of the decision-making process and parties involved was evident in the data collected for this study. Therefore, the emergent model highlights the need for counselors to attend to the potential for system dynamics to impact their decision-making process in either negative or positive ways. Discussion about the need for counselor educator, supervisor, and counselor awareness of system dynamics in the ethical decision-making process is presented later in this chapter.

Outcome Area of Consideration

Outcome was anticipated as a factor in the ethical decision-making process, but the complex and multifaceted nature of the outcome area of consideration was not expected. During the face-to-face interview participants were asked to tell their story from the point they first became aware of their limits to treat the selected client through the process of continued treatment, termination, and/or referral of this particular client. Consequently, generating data about outcome was a natural part of the story-telling process. Although the interview instructions may have generated outcome as an obvious entity in the resolution of a boundaries of competence concern, the data are, nonetheless, interesting and informative.

A review of the literature leads to an expectation that there are two options for resolution of boundaries of competence concerns. Those paths are continued treatment or termination and referral. Although the data collected in this study supported the existence of these two paths as outlined in the literature, the paths were not simple selection processes as might be assumed from the literature. The data revealed complex stories, struggles, and strategies that led to a variety of outcome scenarios, including the reality that counselors do not always control selection of outcome action. Clients sometimes select to declare their intent to terminate or just do not make or attend appointments. The manner of termination reported in this study ranged from clear and direct counselor-initiated or client-determined termination to an ambiguous fading away in which clients simply failed to return to treatment.

The outcome area of consideration is divided into two primary elements. The first primary element is designated as counselor determination and contains two secondary elements: (a) continued treatment and (b) counselor-directed termination and referral. The second primary element is designated as client determination and has two secondary elements: (a) client completes termination following counselor indication of boundaries of competence concern and possible need for referral or - initiated and client-directed termination without counselor suggestion, and (b) client fades away. Outcome primary and secondary elements are shown in Figure 22.

Client and Counselor Determination Outcome Primary Elements

As mentioned previously, a review of the literature creates an anticipation that

outcome involves two straightforward options. However, the reality presented by participants in this study was more complex and multifaceted than these two options suggest. Although all resolutions for participant concerns involved continued treatment or termination, the generally accepted notion that these are clean and clear decisions made by the counselor was not reflected in participant stories. The data, which is the basis of this research-based model for ethical decision making, reveals some variation on this two-part outcome theme.

Outcome is one of three areas of consideration containing secondary elements. The counselor determination secondary elements have to do with whether counselors select and implement their action for resolutions. Counselor-determined outcomes were either (a) continued treatment or (b) termination and referral. The client secondary elements relate to the circumstances surrounding the client-directed termination. The particulars of how termination occurred ranged from clear and direct counselor-initiated or client-determined termination to an ambiguous fading away in which clients simply failed to return to treatment.

Counselor-Determined Continued Treatment and Termination Secondary Elements

Nine participants experienced counselor-directed outcomes. Four of these selected to continue treatment. Two worked with their respective clients to reach this resolution. Two participants decided to continue treatment, outlined their rationale, and set out limits during the face-to-face interview. One of the participants who selected continued treatment did so by using a creative team approach to resolve her

concerns. The second therapist handled the material this particular participant felt was beyond her competence. This allowed her to stay engaged with the client but avoid being outside her competency. Five participants initiated and directed the termination process. Two of these participants indicated negative system dynamics heavily influenced the decision for termination and considered the selection of termination as contributing to negative client outcomes. More discussion is presented on the possibility of creative action plans for resolution of boundaries of competence concerns later in this chapter.

*Client-Determined Termination Secondary Element*s

There are two client-determined termination secondary elements. They are (a) client-directed termination and (b) client faded away. Five participants experienced client-directed terminations. Three of these terminations occurred after the counselor revealed his or her boundaries of competence concerns. In these particular cases, the clients either quickly or eventually ended the relationship with some direct action such as not rescheduling when invited to at the end of what turned out to be the last session, calling to cancel abruptly (terminating by phone), or being angry at the therapist for "failed" treatment and leaving the last session declaring not to return. Two participants experienced abrupt client-directed terminations after mentioning their concerns and inviting clients to work with them for resolution. Two participants reported situations where no mention was made to the client about boundaries of competence concerns and yet, the client terminated. One of these clients did so in a very direct phone

conversation and the other simply faded away. The participant who experienced his client simply fading away reported this, what he believed to be a negative outcome, as a consequence of negative system dynamics.

The research-based emergent model for ethical decision making in boundaries of competence concern situations is grounded in participant data that (a) highlight the complexity of clinical outcomes, (b) point out the potential for varied outcome scenarios, (c) point out the need for counselors to deal with the possibility of client-determined termination as resolution, and (d) underscore the importance of considering the potential impact of system dynamics on outcome. Outcome decisions may be made as counselor and client work together for resolution or independently by either counselor or client. Participant data demonstrated counselor-determined terminations are accompanied by referral options for alternate services that might better meet the client's need(s). This is in keeping with ethical standards, and the emergent model requires counselors to offer referral options when selecting termination as resolution for their concern(s). The emergent model also draws attention to the reality that both system and supervision dynamics can impact or even determine outcome. More discussion and rationale about these factors of the emergent model are set forth in the literature comparison and discussion sections of this chapter.

Outcome Flow Lines

There are two flow lines associated with outcome. One line flows into the outcome area of consideration and the other flows out of this area. The single-point

arrow line flowing from the therapeutic relationship to outcome is intended to illustrate that a resolution to the boundaries of competence concern is reached after establishing a working alliance, considering client needs and circumstances, working with the client, consulting other professionals, utilizing available professional resources. This line essentially signifies the final gathering of all interactions, information, and considerations that inform the decision for resolution and is where the resolution action is implemented by counselor, client, or both. The second flow line moves from outcome to aftermath/post-outcome reflection and is discussed along with the presentation of the aftermath/post-outcome reflection area of consideration.

Aftermath/Post-Outcome Reflection Area of Consideration

Although the interview instructions asked participants to tell their stories "through the process of continued treatment, the termination, and/or referral" of the selected client, 12 participant transcripts included aftermath and/or post-outcome reflection data. The two participants who did not include post-outcome reflection data in their stories were engaged with their selected clients at the time of the interview and made a decision for continued treatment during the interview process. The CMT used for data collection in this study is essentially a free-association exercise. In their free-association story-telling, all of the participants who reported an outcome also reported post-outcome reflections about satisfaction with the clinical process, lack of satisfaction or unsettledness with outcome, and/or growth realized related to selected clinical and decision-making processes. The factors highlighted for post-outcome

consideration in the emergent model came out of the multifaceted aftermath/post-outcome reflections reported by participants.

The title of this area of consideration intentionally alerts counselor educators, supervisors, and counselors to two significant post-outcome dynamics: (a) the potential outcome dynamics to create significant struggles and feeling responses for counselors, and (b) the need for and value of post-outcome reflection. The term *aftermath* was given voice by one of the participants who labeled the final content symbol in his conceptual map (Figure 9) *The Aftermath*, and highlights the reality of potential post-outcome counselor struggles and difficult feeling responses. Participants' feeling responses ranged from satisfied to unsatisfied, contented to conflicted, and delighted to painful. The term *post-outcome reflection* is drawn from the data collected for this study and recognizes recommendations for decision making found in ethics literature (Corey et al., 2007; Hill et al., 1995; Remley and Herlihy, 2005; Stadler, 1986; Welfel, 2006). Reflection, as presented in this component, is intended to alert counselors to the need for reflection following implementation of actions selected for resolution in difficult clinical decision-making situations. For the participants in this study, these reflections revealed a mix of satisfaction, dissatisfaction, unsettledness, conflict, and growth.

There are three primary elements in this component. The first and second have to do with counselor assessment of and feelings about clinical and outcome dynamics. These two are discussed under the heading satisfied and unsatisfied/unsettled primary elements. The third, which is presented under the heading of growth realized primary

element, alerts counselors to the need for and value of post-outcome assessment and reflection about the decision-making process. The aftermath/post-outcome reflection area of consideration primary and secondary elements are illustrated in Figure 22. Individual participant aftermath/post-outcome reflection responses are outlined in Table 34 in Chapter 5.

Assess and Attend to Feeling Responses Related to Clinical and Decision-Making Process Primary Element

The two primary elements, satisfied and unsatisfied/unsettled, are reflective of participant communications about the clinical processes and outcome dynamics they encountered in their selected client cases. Reflections were reported as clinical assessments, feeling responses, and growth realized. The third primary element in this area of consideration addresses the *growth realized* portion of reflection. Participants talked about their assessments of the clinical and decision-making processes including outcome for client, supervision dynamics, and impact of system dynamics. Their assessment responses ranged from satisfied to unsatisfied. They also reflected on and emoted about their own feeling responses related to clinical process and outcome. In the emergent model the acts of post-outcome assessment and acknowledgment of counselor feeling responses are encouraged regardless of clinical outcome or decision-making dynamics.

Satisfied with Clinical Process Secondary Elements

Participant post-outcome reflections of being satisfied were not linked solely to cases with ideal or simple outcomes. Both participants reporting continued treatment as resolution for their concerns reported satisfaction with the clinical process, their selected resolution action, and their ongoing treatment with selected clients. The ten participants who reported termination as resolution to their concerns had a variety of termination experiences. Four of these participants reported satisfaction with clinical and outcome processes. Two reported satisfaction with their clinical work but were unsatisfied with outcome dynamics. Four were unsatisfied with both clinical and outcome dynamics. Interestingly, satisfaction was indicated by two participants who encountered client-directed terminations. More will be said about the role of reflection on satisfying clinical outcomes and decision-making processes in the literature and discussion sections of this chapter.

Unsatisfied/Unsettled About Outcome Dynamics Secondary Elements

The level of dissatisfaction and/or counselor-reported internal conflict varied greatly among the participants. Six participants reported a sense of dissatisfaction with outcome dynamics. Four participants reported a lack of closure. Three participants reported this lack of closure as creating a struggle for them but presented the situations as not significantly impacting the landscape of their professional lives. One participant reported this lack of closure as a haunting experience that had woven itself through his clinical soul for years. The two participants who reported conflict and pain around

outcome dynamics were very expressive about how incredibly hard they had found it to come to terms with what had happened to them and their clients. It is interesting to note that negative system dynamics were reported by the one participant who was haunted by lack of closure and the two who reported very painful feelings around outcome dynamics. The emergent model alerts counselors to the potential for difficult system and outcome dynamics. The model also highlights the need for counselors and supervisors to attend to the potential feelings of emotional distress counselors can encounter when involved in difficult decision-making processes.

Growth Realized Primary Element

The intent of this element in the emergent model is to alert counselors to the need for reflection whether they were satisfied, unsatisfied, and/or unsettled with the clinical process and/or decision-making process. Reflection, in the emergent model, is seen as a potential professional growth opportunity. Participant data demonstrate that post-outcome reflection is a valuable tool for enhancing professional learning and growth.

Although only five participants reported growth as a direct result of involvement in their selected client cases and ethical decision-making processes, it cannot be concluded that other participants did not experience growth resulting from their reported experiences. No direct inquiry was made with any participant regarding professional growth resulting from selected client case experiences. Additionally, this was a time-limited, semi-structured interview that took a brief snapshot of participant

experiences. Consequently, it is conceivable that other participants did experience some professional growth resulting from their work with selected clients but did not happen to report this during the face-to-face interview. Some participants did verbalize insights regarding professional self, clinical work, and/or decision making in general when asked about their reaction to the CMT. This material is presented within the participant reaction to the research tool section of this chapter.

Participants reported insight and/or growth in the area of professional self and identity. While reviewing his map, one participant reflected, "It was an awesome challenge, something to grow on." One participant was passionate about her growth and learning and stated that the case "changed how I viewed my job with clients and I gained a deeper understanding of the seriousness of mental illness." She talked about learning about her power as a professional and adapting a position of advocate for her clients that had become core to her thinking and professional practice. These examples serve to highlight the value of aftermath/post-outcome reflection as the end point in the ethical decision-making process as put forth in the emergent model. More about the rationale behind this decision-making factor is presented in the literature comparison and discussion sections of this chapter.

Aftermath/Post-Outcome Reflection Impact Flow Line

The final flow line in the emergent model is the single-point arrow line moving from outcome to aftermath/post-outcome reflection. This line indicates impact more than interaction. Although it is true that participant reflections were processes of

interacting with all of the dynamics, considerations, factors, and elements of their decision-making processes, the tone of their reflections spoke about the impact the selected clients, their therapeutic journeys, and outcome had on themselves as professionals. Consequently, this flow line is called an impact flow line, which is different from all of the other flow lines in the model. Within the therapeutic relationship, the lines between counselor and client are interactive. The system and supervision dynamics flow lines are seen as both interactive and impacting. The outcome flow line is seen as a line for gathering the process and implementing the decision for resolution. Only the aftermath/post-outcome flow line is primarily an impact line. This is directly reflective of participant data and is intended to alert counselors to attend to the impact, whether delightful or difficult, of the decision-making process on their person and professional selves.

The emergent model can be summarized as a research-based interactive and non-linear model for ethical decision-making specific to boundaries of competence concern situations. The model has five major areas for consideration: the therapeutic relationship, supervision dynamics, system dynamics, outcome, and aftermath/post-outcome reflections components. Each component contains two or more primary elements that highlight factors to be attended to in the given area of consideration. The therapeutic relationship area of consideration is the core and also the starting point of the decision-making process. Flow lines in the emergent model indicate interactive movement and/or impact between areas of consideration. There are three interactive flow lines within the therapeutic relationship component highlighting relational

dynamics between counselor and client. This model emerged out of the data collected for this study and, as is consistent with grounded theory qualitative research, is the end result of data analysis.

COMPARISON OF EMERGENT MODEL TO RELEVANT LITERATURE

The fourth research question proposed for this study was "how does the ethical decision-making process of the practicing professional counselor compare with the ethical decision-making models currently found in the literature?" Literature on ethical decision-making models, their common components, boundaries of competence, fundamental elements of competent practice, and basic concepts involved in ethical decision making in boundaries of competence situations were reviewed in Chapter 2. Discussion addressing question four focuses primarily on a comparison of the components and elements of the emergent model with the common components of ethical decision-making models found in the literature. Comparison of the emergent model with the literature also includes some consideration of the fundamental elements of competent practice and the three basic concepts involved in ethical decision making when boundaries of competence concerns emerge. The first basic concept in boundaries of competence concern decision making is identifying and clarifying. This includes counselor awareness of limits and the viability of possible resolution options, including consideration of resources and established professional standards for entering new practice domains. The second and third concepts involve selecting an action to either (a) continue treatment or (b) terminate and refer.

Table 35 summarizes the similarities and differences between the emergent model and the models for ethical decision-making found in the literature. Although the literature comparison discussion includes some reference to general ethics literature and boundaries of competence specific literature, the comparison table references only ethical decision-making models found in the literature and reviewed for this study. It should be noted that the models found in the literature are designed for resolving a broad range of ethical dilemmas and the emergent model is based on data related to boundaries of competence ethical dilemmas. However, no models of decision making specific to boundaries of competence concerns were found in the literature. Factors impacted by boundaries of competence literature, but not general ethics or ethical-decision making literature, are reviewed in the literature comparison discussion but not in Table 35.

Similarities and differences between the emergent model and model of ethical decision making found in the literature, as outlined in Table 35, give an overview of the significance of the findings that emerged in the analysis of the data. Details of these similarities and differences are presented in the literature comparison discussion. Column one lists the five major areas of consideration formed as categories in the data analysis. The second column lists the primary, secondary, or tertiary elements and flow lines within each of the areas of consideration. The third and fourth columns show the comparison between the data collected for this study and models of decision making found in the literature for each area of consideration or listed element. Column three, which is labeled Literature Supported, indicates compatibility between factors

Table 35

Similarities and Differences between Emergent Model and Models of Ethical Decision-Making Found in the Literature

Area of Consideration	Element/Flow Lines	Summary of Emergent Model Factors Compared to Ethical Decision-Making Models found in the Literature	
		Literature Supported	Unique Contribution
Therapeutic Relationship			X
	Client Dynamics		X
	Background	X	
	Approach to Treatment		X
	Counselor Dynamics		X
	As Professional	X	
	Virtue	X	
	Feeling Responses	X	
	Awareness		X
	Use of Professional Resources	X	
	Actions/ Strategies		X
	Flow Lines		
	Working Alliance		X
	Considering Principles	X	
	Working with the Client		X

(continued on following page)

Table 35 (continued).

Area of Consideration	Element/Flow Lines	Summary of Emergent Model Factors Compared to Ethical Decision-Making Models found in the Literature	
		Literature Supported	Unique Contribution
Supervision Dynamics			X
	Consult Colleagues		X
	Evaluate and Attend to Potential Dynamics		X
System Dynamics			X
Outcome			X
	Counselor Determined	X	
	Client Determined		X
Aftermath/ Post-Outcome Reflection			X
	Assess Clinical and Decision-Making Processes	X	
	Attend to Feeling Responses		X
	Reflect on Growth		X

for consideration in the emergent model and those found in models of decision making in the literature. Column four, which is labeled Unique Contribution, lists factors in the emergent model that either add some significant dynamic to current literature on ethical decision making or contribute a completely new factor for consideration to the body of ethical decision-making literature. The therapeutic relationship area of consideration is the only area with secondary or tertiary elements and flow lines listed out for comparison in Table 35. There was not a perceived need to separate out the secondary elements of the other areas of consideration for Table 35. Comparison of linear or non-linear patterns of decision making are also discussed in this literature comparison section but are not listed in Table 35.

Comparison of the model to relevant literature is broken into six sections. The first section addresses overall decision-making style (e.g. linear or non-linear). The next five sections correspond to the five areas of consideration in the model. In Chapter 2, the common ethical decision-making considerations were summarized in Tables 7 through 11. The literature comparison in this chapter frequently refers back to those tables as a short-hand point of reference for readers.

Decision-Making Process Style: Interactive Non-Linear

The style and nature of the decision-making process within ethical decision-making models is addressed by many authors in presenting their models (Betan, 1997; Cohen & Cohen, 1999; Corey et al., 2007; Cottone, 2001, 2004; Garcia et al., 2003; Haas & Malouf, 1995; Hanson & Goldberg, 1999; Hill et al., 1995; Kitchener, 1984b,

2000; Remley & Herlihy, 2005; Rest, 1884, 1994) and/or critiquing other models (Betan; Hill et al.; Remley & Herlihy). Corey et al., Hill et al., and Remley and Herlihy have attempted to discourage the traditionally linear approach to ethical decision-making. Betan challenged the traditional non-relational and linear moral reasoning models and suggested a more relational and interactive model without eliminating moral reasoning from the decision-making process. Hill et al. expressed their concern about the non-relational tone in traditional models. Remley and Herlihy (2001) pointed out that traditionally "models have tended to be linear, logical, rational, dispassionate, abstract, and paternalistic" (p. 12).

The process styles presented within the primary theory-based models are an assortment of linear, accused of linearity, not intended to be linear, hierarchical, and interactive. Rest (1994) indicated that the four components of his model are not intended to outline a linear process but a complex interaction of four components that "comprise a *logical* analysis of what it takes to behave morally" (p. 24). Kitchener (1984b, 2000) described the diagram of her model as being "arranged to suggest that there are different levels of moral reasoning and that they are hierarchically related" (2000, p. 11). The feminist model presented by Hill et al. (1995) stressed an interactive and nonlinear decision-making process. It is the feminist model presented by Hill et al. that is the most direct, clear, and frequently cited regarding the importance of an interactive and nonlinear decision-making process as the preferred method of decision-making.

All but one presentation of the primary practice-based models addressed the issue of linear thinking in the ethical decision-making process directly or indirectly. Forester-Miller and Davis (1996) did not comment on linearity in presenting their model. Corey et al. (2003) and Remley and Herlihy (2001) argued that ethical decision making is not a linear process, and the consequent models they presented were not intended to be followed in a step-by-step fashion. Welfel (2002) did not directly address linearity within the presentation of her model, but indicated several steps or portions of steps needed to be attended to throughout the decision-making process in a back-and-forth type process. Remley and Herlihy indicated that their selection of "elements" rather than steps encourages the feminist idea of processing in a nonlinear manner.

A number of the theory-based and practiced-based secondary ethical decision-making models discussed in this review addressed the issue of process style. Cottone's (2001; 2004) constructivism model presented ethical decision making as an interactive process involving negotiating, consensualizing, and arbitrating. Cohen and Cohen (1999) presented an interactive yet systematic set of steps intended to outline a dynamic process. Betan (1997) asserted that his hermeneutic model is an interpretive-interactive process of ethical decision making anchored in the context of therapeutic relationships. Hanson and Goldberg (1999) intentionally presented their model as a "matrix or web" (p. 501) and contended resolving ethical difficulties "cannot be neatly placed in decision trees, like diagnostic determinations" (p. 501). According to Garcia

et al. (2003), their transcultural integrative model "involves a step-by-step linear method" (p. 275).

It would appear that the trend in the literature related to ethical decision-making style is to suggest a non-linear and, in some cases, interactive or relational style of decision making. The participant data collected for this study suggest that the decision-making patterns of counselors in the field parallel this trend in the literature. The emergent model for ethical decision making is an interactive and non-linear model for ethical decision making.

Therapeutic Relationship Area of Consideration

Ethics literature refers to the therapeutic relationship and ethical decisions on a number of levels, but models of ethical decision making do not overtly reference the therapeutic relationship as an overarching dynamic entity factoring into the decision-making process. The therapeutic relationship is core to the emergent model and the starting point of the decision-making process. In this interactive/non-linear model the entire process of decision making flows in and out of the therapeutic relationship and between the parties involved in the relationship. Various elements of the therapeutic relationship are major considerations in a number of the models reviewed for this study and some of the elements are referenced in minor ways during the course of model presentations. Before beginning the comparison of relevant literature and the elements of the therapeutic relationship in the emergent model, a brief overview of ethics literature on the therapeutic relationship is offered.

Within ethics literature ethical conduct is seen as foundational to the therapeutic relationship contract. According to Van Hoose and Kottler (1988), any discussion of professional ethics must include an awareness of the therapeutic relationship as having a unique contract. Wolman (1982) declared two decades ago that violating the therapeutic contract is not an option for ethical counselors. According to Remley and Herlihy (2005), counselors who realize the extraordinary responsibilities intrinsic to the work of psychotherapy are serious about ethics.

There is a great deal in the literature about the power differential in the therapeutic relationship necessitating careful attention (Carroll, 1997; Kitchener, 2000; Remley & Herlihy, 2005; Van Hoose & Paradise, 1979; Welfel, 2006). Failure on the part of the counselor to recognize the unequal distribution of power inherent in the therapeutic relationship precipitates ethical difficulties (Kitchener; Stein, 1990; Welfel). Guidelines for avoiding this potential ethical quagmire resulting from power differential dynamics are found in codes of ethics and professionally outlined moral principles (Meara et al., 1996; Welfel). According to Meara et al., the natural dynamics within therapeutic relationships (e.g. inherent power differential) ethically obligate counselors to practice within the mandates of fidelity.

Ethics literature and the emergent model view the consideration of the therapeutic relationship as critical and even central to sound ethical behavior and ethical decision making. The similarity between ethics literature and the emergent model is obvious. The lack of clear and stated recognition of and emphasis on the therapeutic relationship in the ethical decision-making models presented in the

literature is in contrast to overall ethics literature and the emergent model. Ethical decision-making models presented in the literature reference a number of the elements found in the therapeutic relationship area of consideration but none of them emphasizes the therapeutic relationship as a factor in ethical decision making. It could be speculated that the authors of the models found in the literature presuppose the importance of the relationship, and therefore have not included this factor in models that have already been criticized as too cumbersome (Welfel, 2006). However, the participants in this study made it clear that the therapeutic relationship is a core consideration in the decision-making process.

Client Dynamics Primary Element

In the emergent model the client dynamics primary element is broken into two secondary elements: (a) client background and (b) client presentation and approach to therapeutic process. Ethics literature does offer some parallels to the human dignity aspects of the client background secondary element, and models for ethical decision making found in the literature offer steps of consideration for client context. Nothing was found in ethics literature or ethical decision-making models presented in the literature addressing the influence of client presentation and approach to the therapeutic process on ethical decision making.

Client Background Secondary Element

The client background element in the emergent model clearly encourages counselors to extend dignity to clients, and to consider their background and ongoing context. For the participants in this study, extending dignity to clients meant speaking about them in a graciously humane manner and considering life circumstances and context that brought them to treatment. There was no trace of sterile clinical judgments void of human compassion and respect of clients in the transcripts of these participants. Client context was a continual consideration as participants told their stories of decision making. Both of these considerations are evident in ethics and/or the ethical-decision making models presented in the literature.

Human dignity tertiary element and ethics literature. Promoting client welfare, protecting client dignity, and avoiding or minimizing potential harm are the cornerstones of ethical behavior (Gross & Robinson, 1987; Lakin, 1991; Stein, 1990; Wolman, 1982). According to these authors, the primary intent of the therapeutic contract is to promote client welfare and dignity. Each of the codes of ethics to which the participants in this study are responsible declare promoting client welfare and protecting human dignity as primary. The *ACA Code of Ethics* (2005) is the primary code participants are responsible to uphold. The *ACA Code of Ethics* states, "the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients" (Section A.1.a).

The manner in which participants spoke of their clients is in keeping with standards set in ethical codes. The emergent model encourages counselors to attend to

client dignity and welfare. None of the models for ethical decision making found in the literature overtly addressed this factor. However, it should be noted that the ethics texts developed by Corey et al. (2007), Remley and Herlihy (2005), and Welfel (2006) for counselor training in ethics, in which their models for ethical decision making are embedded, each link ethical behavior and protecting the dignity and welfare of clients.

Contextual sensitivity tertiary element. In the emergent model, consideration of client background and context is an important factor in the decision-making process and similar to considerations offered in ethical decision-making models presented in the literature. In ethics literature client context is sometimes referred to as contextual sensitivity and linked to multicultural competencies. Contextual sensitivity addresses a broad range of concerns that emerge within the environmental framework of the therapeutic relationship. Context includes consideration of "age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, and socioeconomic status" (ACA, 1995, Section A2a.) of the client and other affected parties. Attending to counselor values is also included under the general rubric of contextual sensitivity.

The primary theory-based model of Hill et al. (1995) emphasized contextual sensitivity. Remley and Herlihy (2001) offered significant discussion concerning contextual sensitivity within the introduction to their model. There is no discussion of contextual sensitivity within the presentation of the other primary models reviewed in this chapter. Discussion of this area of consideration is present in the secondary model presentations of the social constructivism model of Cottone (2001, 2004), the virtuous

therapist model of Cohen and Cohen (1999), the hermeneutic model of Betan (1997), the models of Woody (1990), and Hanson and Goldberg (1999), and the transcultural integrative model of Garcia et al. (2003).

In the literature, contextual sensitivity includes awareness of potential differing values held by counselor and client. In presenting their model Corey et al. (2007) pointed out that the ethical decision-making process is a value-laden process, and highlighted the need for counselors to be conscious of their own and their clients' values. Betan (1997) contended that contextual dynamics and the experiences and values counselors bring to the therapeutic relationship influence the decision-making process. According to Corey et al., Brace (1997), and Tjeltveit (1999) there are times when counselor values influence the therapeutic process. Stadler (1986) emphasized that, in the course of clinical work, counselors are not "neutral, unbiased observers of the lives that pass before [them]" (p. 3).

When counselors face difficult ethical dilemmas they are often encouraged to attend to their own values (Kitchener, 1984b, 2000; Remley & Herlihy, 2001). Kitchener (1984b) pointed out that professional values are not arbitrary. As members of the counseling profession, counselors agree to professional standards that delineate some actions and values as desirable and others as undesirable (Kitchener, 1984b, 2000; Stein, 1990). According to Corey et al. (2003) counselors are expected to realize clients will be influenced by counselor values, and therefore must attend closely to situations where client and counselor values conflict. The literature is much stronger about the issue of counselor values than is the emergent model. However, attending to

values, particularly value differences between counselor and client, is a factor in the emergent model.

Impact of Client Presentation/Approach to Therapeutic Process Secondary Element

Research data, which formed the factors for consideration in the emergent model, revealed a pattern of counselor decision making influenced by both client presentation and approach to treatment. Client presenting issues, background, how clients presented their concerns, alerted participants to a boundaries of competence concern and influenced decision-making processes. Participants spoke of client presentation in sessions and the approach clients took to treatment interventions as factors influencing their course of decision making. Client presentation in sessions and approach to treatment interventions ranged from resistance to eager engagement in the treatment process, inability to process material effectively to smooth progress in treatment, and disturbing seductive behavior to presentations that were comfortable or even endearing for participants. As mentioned earlier, nothing was found in ethics literature or ethical decision-making models presented in the literature that discussed consideration of client presentation and/or client approach to treatment as a factor in ethical decision making.

Counselor Dynamics Primary Element

In the emergent model, counselor dynamics primary element is broken into three secondary elements: (a) counselor as professional, (b) counselor as person: the

counselor's heart, and (c) awareness of and response to boundaries of competence concerns secondary element. Ethical decision-making models found in the literature and/or general ethics literature contain parallels to most of the secondary and tertiary elements making up the counselor dynamics primary element. However, there are some dynamic differences in the counselor awareness and action/strategies factors for consideration within the element.

Counselor as Professional Secondary Element

There is a difference between consideration of counselor as professional as a factor in ethical decision making within the emergent model and models of decision making found in the literature. In the emergent model, counselor as professional refers to the development of the professional self. The measurable components of this element include completion of a master's degree, being licensed, and the utilization of professional resources. It is worth pointing out that there is more to the professional self than these measurable components. Each participant brought some intangible components to the process including either professional confidence or timidity, conscious or unconscious moral reasoning, general experience or lack of experience, and a honed or novice skill development. All of these permeated their stories of decision making. This secondary element encourages counselors to assess their professional development as a part of the decision-making process. Actually seeking out professional resources in the process of decision making is not included in this

secondary element, but is considered as part of the counselor awareness of and response to boundaries of competence concerns secondary element.

As with other elements in the therapeutic relationship area of consideration, the development of a professional self element is not directly included in models in the literature. However, it would be askew to say that the authors of models in the literature did not give consideration to this element. It is clear in the material surrounding model presentations, particularly those of Corey et al. (2007), Remley and Herlihy (2005), and Welfel (2006) that authors of models found in the literature were mindful of the training and development needed for counselors to enter into the decision-making process in ethically sound ways.

The emergent model, however, includes this element as part of the decision-making process because participants clearly referenced their foundational training experiences throughout their stories of decision making. They either referenced their basic training and subsequent professional development involvements as providing foundational guidance for their decision-making processes or indicated disappointment with their master's-level training in one or more areas. Participants also referenced their status as novice counselors in offering self-understanding of their management of cases reported from years past. These pieces of data informed the inclusion of this element in the model encouraging counselors to carefully and honestly evaluate their professional assets and deficits during the process of decision making.

Counselor as Person: The Counselor's Heart Secondary Element

There are two tertiary elements within the counselor as a person secondary element. The first is virtue ethics: counselor character. The second is impact of counselor feeling responses during the decision-making process. These are illustrated in Figure 22 as virtue/character and feelings.

Table 7 in Chapter 2 contains three components and is labeled counselor makeup: common components of ethical decision-making models. The first is virtue and values. The second is moral sensitivity, more currently referred to as ethical sensitivity (Welfel, 2006), and the third is contextual sensitivity. The values portions of the first component and the third component, which is contextual sensitivity, are addressed in the client background secondary element within the emergent model. The moral sensitivity component is not separated out from the virtue element in the emergent model, but is subsumed within the virtues and feeling response tertiary elements.

Virtue ethics: Counselor character tertiary element. The emergent model, ethics literature, and models of ethical decision-making found in the literature all address counselor virtue. Ethics literature and ethical decision-making models found in the literature encourage counselors to be virtuous therapists. Several authors (Cohen & Cohen, 1999; Jordan & Meara, 1990; Meara et al., 1996) have challenged the mental health professions to give more consideration to virtue ethics in understanding ethical decision making.

For the counseling profession, the core question in virtue ethics centers around what kind of character is essential for being a counselor (Remley & Herlihy, 2001). There is some consensus in counseling literature about the particular virtues or character qualities desirable for the professional counselor. The five most agreed-upon virtues can be grouped as prudence or practical wisdom, integrity, respectfulness or being tolerant, trustworthiness or conscientiousness, and compassion or care (Corey et al., 2007; Kitchener, 2000; Remley & Herlihy, 2001).

Four of the seven primary models for ethical decision making reviewed in Chapter 2 include consideration of virtue as a factor in the ethical decision-making process. Those four models are the models presented by Rest (1984, 1994), Kitchener (1984b, 2000) the feminist model of Hill et al. (1995), and Remley and Herlihy (2005). The Cohen and Cohen (1999) model is the one secondary model reviewed in Chapter 2 that places major emphasis on counselor virtue.

Moral sensitivity or ethical sensitivity, as a part of counselor makeup, is a consideration presented within several of the models for ethical decision making in the literature and summarized in Table 7. The moral sensitivity component found in models presented in the literature addresses counselor ability to recognize, understand, clarify, and implement a moral response to ethical concerns within the clinical setting. The primary models of Rest (1984, 1994), Kitchener (1984b, 2000), Hill et al. (1995), Remley and Herlihy (2005), and Welfel (2006) include consideration of moral sensitivity. No mention of moral or ethical sensitivity is found in the Forester-Miller and Davis model (1996). Within the secondary models reviewed for this study, only

the works of Hare (1981) and Tarvydas (1998) discussed the concept of ethical sensitivity.

Hill et al. (1995) and Remley and Herlihy (2005) have argued that moral sensitivity, more currently referred to as ethical sensitivity (Welfel), requires counselors to attend to their feelings. Although the emergent model does not develop moral sensitivity as a separate element, there is room for moral sensitivity concerns to be addressed within

(a) virtue ethics: counselor character and (b) impact of counselor feeling responses on the decision-making process tertiary elements.

Impact of counselor feeling responses on the decision-making process tertiary element. Recognition that counselor feelings impact the decision-making process is evident in ethics literature, several of the models for ethical decision making reviewed for this study, and the emergent model. According to Van Hoose and Kottler (1988), ethical decisions develop out of a counselor's "feelings, beliefs, prejudices, and experiences" (p. 170). Corey et al. (2003) encouraged counselors to develop their own ethical positions but cautioned the practitioner not to make ethical decisions based solely on personal feelings or intuition because feelings and personal interpretation influence ethical decisions. Koocher & Keith-Spiegel (1998) and Van Hoose & Kottler (1988) warned that counselors guard against feelings related to personal, social, or economic pressures blurring their understanding of practice limits and the possible need to refer. Leigh (1998) encouraged counselors who need to refer for boundaries of competence and other reasons to attend to the powerful feelings that

accompany such a decision. In spite of the importance of counselor feelings impacting the decision-making process only three models found in the literature (Hill et al., 1995; Remley & Herlihy, 2005; Rest, 1984, 1994) emphasized this as a consideration.

The Rest (1984, 1994) theory-based model offered clear cautions about counselor feelings impacting the decision-making process. Rest argued that some situations will call forth strong feeling responses that may cause a person to "proceed without waiting for a considered judgment and careful weighing of the facts" (Rest, 1984, p. 21). He noted that these strong reactions can sometimes direct individuals to higher moral action, but, at other times, he cautioned these responses may hinder good judgment.

The Hill et al. (1995) and the Remley and Herlihy (2005) models overtly address the impact of counselor feelings on decision-making. The feminist model presented by Hill et al. is an interplay between thinking and feeling, and feeling and thinking that weaves the need for counselor attention to feeling responses at each step along the way. The authors contended that identifying, sorting out, and attending to feelings in a troublesome clinical situation are fundamental tasks for counselors. They argued that attending to feelings is critical because feeling responses, including countertransference feelings, are useful for continued insight as counselors move through the decision-making process. Remley and Herlihy list eight common elements in ethical decision making. The third element encourages counselors to be intentional about listening to and understanding their feelings related to the situation in question. According to Remley and Herlihy, this self-examination process is important because

it may uncover life experiences and emotional responses that could potentially influence the decision-making process. Hill et al. and others (Remley & Herlihy, 2005) have argued that moral sensitivity, more currently referred to as ethical sensitivity (Welfel), requires counselors to attend to their feelings.

Awareness/Response to Boundaries of Competence Concerns Secondary Element

The discussion of this secondary element and its comparison to the literature is broken up into three sections: (a) awareness of boundaries of competence issue(s), (b) response to concerns: utilization of professional resources, and (c) response to concerns: actions and strategies. The research data that formed the emergent model is full of participant responses to their boundaries of competence concerns. Many of these responses were multidimensional and overlap or interact with areas of consideration (e.g. supervision and system dynamics) or designated by flow lines. Considering and/or working out of the therapeutic alliance, considering the client and applying moral principles, and working with the client are represented by the flow lines moving between counselor and client. The flow line moving from the therapeutic relationship area of consideration to the outcome area of consideration represents implementation of the decision. These flow lines are shown in Figure 22. Consequently, the only counselor responses addressed within this secondary element are related to utilization of professional resources and actions or strategies that precede implementation of actions directly leading to outcome.

Awareness of boundaries of competence issue(s) tertiary element. Recognizing a problem, clearly identifying and clarifying the dimensions and parameters of the problem are important to the decision-making process within the emergent model and the models of ethical decision making found in the literature. As summarized in Table 9 the primary models of Hill et al. (1995), Forester-Miller and Davis (1996), Remley and Herlihy (2005), Welfel (2006), and Corey et al. (2007) list identifying and clarifying as a component or step in the ethical decision-making process. A number of the secondary models reviewed for this study (Cottone, 2001, 2004; Cohen & Cohen, 1999; Haas & Malouf, 1995; Garcia et al., 2003) also address the need for counselors to identify and clarify the issues and concerns related to ethical dilemmas they are facing.

In the models presented in the literature, identifying and clarifying are generally the starting points for the decision-making process. The emergent model begins with the therapeutic relationship area of consideration, which is a very complex set of considerations related to counselor and client dynamics. This is not to say that the starting point of the emergent model does not include identifying and clarifying, which is recognized as *awareness* in the emergent model, but it does perhaps convey a dynamic difference between this research-based model and those found in the literature.

In general, identifying and clarifying as presented in the decision-making models found in the literature is a rather academic and static step in the process. In the data that formed the emergent model, awareness was for some participants a moment-in-

time experience of insight, but for others it was a dynamic that unfolded over time. In either case participant awareness of their concern was reported as full of dynamics, which provided rich data about the twists and turns of identifying and clarifying.

Response to concerns: Utilization of professional resources tertiary element. The emergent model and models of ethical decision making found in the literature encourage counselors to consult professional regulations, literature, and colleagues during the course of difficult ethical decision-making processes. Three of the six components listed in Table 9 include possible actions relevant to utilization of professional resources found in models reviewed for this study. As mentioned in the presentation of the emergent model section related to this tertiary element, supervision or consulting colleagues is its own area of consideration and is not, therefore, addressed in this secondary element. General ethics literature, boundaries of competence literature, and the emergent model add utilization of professional resources, continuing education opportunities (e.g. seminars, workshops, and academic course work), and services provided by professional organizations, to the list.

The professional regulations component in Table 9 and in the emergent model includes ethics codes, legal regulations, and case law. The primary models of Kitchener (1984, 2000), Forester-Miller and Davis (1996), Remley and Herlihy (2005), Welfel (2006), and Corey et al. (2007) all specify consulting professional regulations as a major concern in the ethical decision-making process. A number of the secondary models reviewed in this chapter (Cohen & Cohen, 1999; Garcia et al.,

2003; Haas & Malouf, 1995; Hanson & Goldberg, 1999; Mattison, 2000; Stadler, 1986; Tymchuk, 1981; Woody, 1990) also referenced the need to consult professional regulations.

Encouragement to consult relevant ethics literature is referred to in four of the twenty models reviewed in this chapter (Forester-Miller and Davis, 1996; Haas and Malouf, 1995; Remley and Herlihy, 2005, Welfel, 2006). The Welfel (2006) model is the only model presentation reviewed in this chapter that devotes significant discussion to this component. Welfel argued knowledge of relevant "literature is a necessity, not a luxury, for a competent counselor" (p. 31), and because professional literature is accessible through electronic communication, lacking knowledge of relevant literature could be grounds for judging counselors as incompetent. Using literature as a resource, according to Welfel, can also diminish the sense of isolation when counselors face complex and difficult ethical decisions.

Literature addressing boundaries of competence concerns clearly indicates that counselors may select to continue treatment as a resolution to boundaries of competence issues. When counselors select to continue treatment, they will likely be entering into *new domains* of professional experience. The literature on new practice domains clearly outlines further training and supervision with professionals who have knowledge and experience in the area of concern as an essential part of a continued treatment plan (Pope & Vasquez, 1991: Rinas and Clyne-Jackson, 1988; Welfel; 2002). Tables 14 and 15 in Chapter 2 list ethics statements relevant to new practice domains found in the ethics codes of the ACA (2005), Commission on Rehabilitation

Counselor Certification (CRCC) (2002), American Psychological Association (APA) (2002), National Association of Social Workers (NASW) (1999), and American Association of Marriage and Family Therapists (AAMFT) (2001). It is apparent from these codes that there is a consensus within mental health professions concerning new practice domains. The standard clearly states that counselors who decide to continue treatment and thus enter a new practice domain must take steps to engage in relevant education, training, and supervised experience. The APA (2002) and NASW (1999) standards add the concepts of reviewing relevant research and engaging in study, and thus, underscore two areas of training and preparation needed for competent practice in new specialty areas. Therefore, utilization of professional resources in new practice domain situations includes seeking out continuing education opportunities, researching the literature, and engaging in consultation with colleagues who have an expertise in the area of concern.

The emergent model also encourages counselors to utilize services provided by their professional organizations when encountering situations calling for extended or complex ethical decision-making processes. The ethics texts often used in training counselors (Corey et al. 2007; Remley & Herlihy, 2005; Welfel, 2006) explain the value and power of professional organizations. Society expects professional organizations to set the standards for competence, promote ethical behavior, and act as gatekeepers in order to minimize incompetence (Remley & Herlihy, 2001; Stein, 1990; Van Hoose & Paradise, 1979). Professional organizations, along with licensure boards, investigate reported ethics violations, make decisions, and enact discipline

(Welfel), and also function as resource information sources for their members. When counselors have exhausted all other resources, ACA members can contact personnel within the national organizations, state branch, and/or relevant division(s) to ask strategic questions about licensure laws, legal concerns, ethical issues, and potential resources. They can expect to receive direction that will help them determine the appropriate next step and/or inform them about significant parameters related to their dilemma (Welfel, 2006). Consequently, it makes sense that the organizations charged with oversight of professional ethical behavior be considered a resource when counselors find themselves in difficult situations.

When taken together, boundaries of competence literature, ethical decision-making models found in the literature and the emergent model form a consensus that consulting professional resources is a part of the decision-making process. Counselors who engage in ethical decision making related to boundaries of competence issues and select to continue treatment in new practice domain areas are mandated to utilize continuing education and consultation services. The emergent model includes professional resources, not because of a significant presence of these considerations in the data, but because of the relative absence of participant utilization of these resources. The exception to this absence is supervision. The data concerning supervision were abundant and form a separate area of consideration.

Response to concerns: Actions and strategies tertiary element. The four action steps found in ethical decision-making model literature and listed in Table 10 are generating possible actions, considering outcomes, selecting action(s), and

implementing action(s). In the emergent model these components are not highlighted as independent elements but, with the exception of implementation of action(s), are housed as a unit, as illustrated in the content symbol labeled *Actions/Strategies* shown in Figure 22. Implementation of action(s), in the emergent model, is represented by the flow line moving from the therapeutic relationship area of consideration to the outcome area of consideration.

In the ethical decision-making models reviewed for this study, the components generating possible actions, considering outcomes, and selecting action(s), are present in all but one of the primary models. Each is present in at least one of the secondary models. Some authors presented these as stand-alone steps, but others combined one or two of the steps with other considerations in the decision-making process. Within the secondary models reviewed for this chapter Stadler (1986), Haas and Malouf (1995). Mattison (2000), and Garcia et al. (2003) each included these three action steps (i.e., generating possible actions, considering outcomes, and selecting action[s]) as considerations in the ethical decision-making process.

Although there are authors who combine these steps or present them as intricate parts of other considerations in the decision-making process, most of the primary models reviewed for this study separate out the steps as distinct components of the process (Corey et al., 2007; Forester-Miller & Davis; Hill et al., 1995; 1996; Remley & Herlihy, 2005; Welfel, 2006). Each of these considerations is present in participant data, but participants did not talk about their response to concerns as units of activity that could be divided up into tidy action steps. Their stories of response to resolving

their dilemmas were more like small interlocking, interdependent, inseparable pieces of a larger puzzle. To pull them apart would somehow tamper with the essence of the data.

Therapeutic Relationship Interactive Flow Lines

Discussion of the therapeutic relationship interactive flow lines contains three sections. These sections correspond directly to the three flow lines found in Figure 22 illustrating interaction between client and counselor dynamics. The three sections are: developing working alliance, counselor regard for the client, and working with the client.

Working Alliance

No reference to creating a working alliance or using the working alliance as an intricate part of decision making was found in general ethics literature, models for ethical decision-making found in the literature, or boundaries of competence specific ethics literature. However, it was clear that, for the participants in this study, the working alliance was an intricate part of the decision-making process. Within clinical training literature, the working alliance is taught as an essential part of the therapeutic relationship (Egan, 1998). In the data collected for this study, it was apparent that the presence or lack of a working alliance affected outcome. Consequently, the emergent model encourages counselors to attend to the presence or absence of a working alliance during the decision-making process.

Counselor Regard for Client: Considering Moral Principles

Counselor regard for clients as a factor of consideration in the emergent model is comparable to considerations of moral principles found in models of ethical decision making reviewed for this study. The six moral principles generally listed in ethics literature for guidance in ethical decision making encapsulate the regard of clients that participants demonstrated and/or reported.

A summary of consideration of moral principles common to models of ethical decision making found in the literature is listed in Table 9. All of the major models reviewed for this study, with the exception of Rest (1984, 1994) and Hill et al. (1995), emphasize consideration of moral principles. Many of the secondary models also indicate that consideration of moral principles is a significant step in the ethical decision-making process (Betan, 1997; Garcia et al. 2003; Haas & Malouf, 1995; Hanson & Goldberg, 1999; Stadler, 1986).

Although the feminist model of Hill et al. (1995) does not emphasize consideration of principles, the authors included discussion of principles in their model but indicated caution is necessary in the use of moral principles. Hill et al. argued that in consulting moral principles, counselors need to take heed because interpretation of moral principles may be biased by one's "context of power" (p. 21), which is related to gender, racial identity, and socioeconomic status. Along the same line of thinking, Garcia et al. (2003) argued for consideration of the principle of tolerance within the ethical decision-making process for professional counselors. In the same spirit as the Hill et al. caution and the Garcia et al. request, the emergent

model encourages counselors to give active consideration to balancing consideration of moral principles with an understanding of the Hill et al. context of power concept. This step circles back to the client background considerations/contextual sensitivity considerations discussed in the client dynamics primary element.

Working with Client

Discussion of the importance of working with the client is present in the primary models of Hill et al. (1995), Remley and Herlihy (2005), and Corey et al. (2007). None of the other presentations of the primary or secondary models contain discussion on working with the client. The concept of working with the client throughout the ethical decision-making process as presented in the feminist model of Hill et al. (1995) is grounded in the feminist belief that, when clinically appropriate, the power differential between counselor and client should be equalized as much as possible. Corey et al. (2007) and Remley and Herlihy (2005) indicated that Hill et al. influenced their models.

The data that formed the emergent model indicate that working with the client is a factor in the decision-making process for practicing professional counselors. This is not to say that participants always decided to include clients in the decision-making process. It does say that counselors give consideration to sharing their concerns with the client and decide to share or not share based on clinical judgment and evaluation of circumstances. Inclusion of this consideration in the emergent model is consistent with the models of Hill et al. (1995), Remley and Herlihy (2005), and Corey et al. (2007).

However, nothing was found in these three presentations regarding the possibility that clinical judgment would suggest not working with the client. In this regard, the emergent model differs from the models of Hill et al., Remley and Herlihy, and Corey et al.

In comparing the various elements of the therapeutic area of consideration to the literature there are many similarities and a few differences. The primary difference is that the therapeutic relationship is the core of the emergent model and no literature was found that spoke of the therapeutic relationship as a dynamic entity factoring into the decision-making process. Several of the participants indicated that their bond with the client was a key consideration influencing their decision-making process, but this factor was not present in the ethical decision-making models found in the literature. The literature may be hinting at this topic in discussions of abandonment of clients and/or working with the client. However, the therapeutic relationship as a factor of influence or consideration is not present as a factor for consideration in ethical decision-making models reviewed for this study.

Both client dynamics and counselor dynamics primary elements are to some degree parallel to ethics decision-making literature and/or models of ethical decision making found in the literature. However, as with the therapeutic relationship area of consideration, these concepts are bundled differently in the emergent model than in the literature. Some of the factors for consideration within the client and counselor dynamics primary elements are present in the literature, some are present but the dynamic differs, and one is a new addition to the literature.

Some of the secondary, and/or tertiary elements of the therapeutic relationship were directly parallel to components, steps, or considerations found in the models of decision making reviewed for this study. Elements in the emergent model which have parallel considerations in ethical decision-making literature include: (a) consideration of client background or contextual sensitivity, (b) the training, development, and credentialing involved in a counselor's professional life, (c) attending to virtue or character, including the presence of moral sensitivity, (d) impact of counselor feeling responses on the decision-making process, (e) utilization of available resources, including researching relevant literature and seeking out continuing education opportunities, and (f) counselor regard for the client/attending to moral principles.

Seven of the secondary or tertiary elements within the client and counselor dynamics primary elements, and two of the factors of consideration represented by interactive flow lines within the therapeutic relationship area of consideration, differ from the models found in the literature. The dynamics involved in identifying and clarifying concerns, and the process of selecting actions and/or strategies differ from the step-by-step, clearly defined, linear process described in models of decision making found in the literature. In the emergent model, working with the client around counselor-identified boundaries of competency concerns is an option for consideration. This is consistent with the literature but in the emergent model, there is room for counselors to decide not to share their concerns with clients. Client presentation and approach to treatment and consideration of the working alliance are

factors for consideration in the emergent model not found in models of decision making found in the literature.

Supervision Dynamics Area of Consideration

Encouraging counselors to seek consultation or supervision in the course of ethical decision making is a matter of importance in models for ethical decision-making found in ethics literature, boundaries of competence literature, and the emergent model. The supervision dynamics area of consideration in the emergent model is similar to and also different from the recommendations to consult colleagues found in ethical decision-making and boundaries of competence literature. The similarity is the presence of and emphasis on supervision, consultation, and networking in both the emergent model and relevant literature. There are three differences between supervision dynamics considerations in the emergent model and the general encouragement to seek supervision found in the literature. First is the fact that the emergent model alerts counselors to the potential spectrum of supervision dynamics and relevant literature only states that supervision is needed. Second is that the emergent model encourages counselors to understand and attend to the potential influence of supervision on the decision-making process. Third is that the emergent model alerts counselors to the potential negative impact supervision may have on parties involved in the process. The emergent model encourages counselors to evaluate the influence and impact of supervision on the decision-making process and the parties involved including themselves and their own professional sense of self, and

this encouragement is not present in the models of decision-making reviewed for this study.

Consulting colleagues is one of the components in the information gathering process found in the decision-making models in the literature. A summary of the presence and/or emphasis on supervision dynamics and/or recommendations to consult colleagues is given in Table 9.

Within the primary models only Rest (1984, 1994) and Kitchener (1984b, 2000) omitted consultation with colleagues in presenting their models. The remaining primary theory and practice-based models reviewed for this study (Corey et al., 2003; Forester-Miller & Davis, 1996; Hill et al., 1995; Remley & Herlihy, 2001; Welfel, 2006) included consultation either as a full step within the process of decision making or emphasized the need for consultation as a part of one or several steps. Within the secondary models reviewed for this study, Cottone (2001, 2004), Tymchuk (1981), Haas and Malouf (1995), Stadler (1986), and Garcia et al. (2003) urged counselors to seek consultation. In the social constructivism model of Cottone, consultation is the central pillar of the decision-making process.

Boundaries of competence literature emphasizes the use of supervision when continued treatment is the resolution for a boundaries of competence dilemma. According to Corey et al. (2003), Hass and Malouf (1995), and Welfel (2002), part of assessing the viability of possible resolution options is assessing the accessibility of supervisors who are trained and experienced in dealing with the issues of concern. If the resolution is to continue treatment, supervision is seen as one of the key

components for entering a new practice domain (Corey et al. (2003). The ACA (2005), CRCC (2001), NASW (1999), and AAMFT (2001) codes of ethics all specify that supervision is a necessary component when entering a new practice domain.

Positive, Indistinct, and Negative Clinical Guidance Primary Elements

The emergent model breaks clinical guidance down into three types (i.e., positive, indistinct, and negative) and encourages counselors to evaluate supervision by type, influence on the decision-making process, and impact on the parties involved. Key words that emerged around positive clinical guidance are affirmation, empowerment, support, encouragement, meticulous oversight, growth, challenge, and instruction. Indistinct may seem to be an odd choice of words to describe supervision but it was selected because it captures the supervision experiences recounted by eight of the participants. Synonyms for indistinct include such words as imprecise, blurry, dim, faint, and vague. Each of these synonyms reflects at least one of the eight stories of indistinct clinical guidance. The characteristics of negative clinical guidance experiences were reported as chaotic, disruptive, and confusing, and were filled with contradicting statements embedded in unhealthy system dynamics.

None of the models for ethical decision making reviewed for this study use descriptors indicating quality of supervision. In the latest edition of her ethics text, Welfel (2006) acknowledged that some supervision insights are not useful. She pointed out that sometimes counselors will encounter unethical advice, and indicated that it is not uncommon to encounter conflicting advice. Magnuson, Wilcoxin, and

Norem (2000) called incompetent supervision "lousy supervision" (p. 189). Lousy supervision, as explained by Magnuson, Wilcoxin, and Norem, easily fits the picture the participants in this study painted of indistinct and negative supervision.

Supervision Interactive Flow Lines

There are two flow lines in the emergent model that are relevant to supervision dynamics. One is a double-pointed arrow line going between supervision and system dynamics and indicates the potential intermingling of dynamics between supervisor and system. This line is discussed within the system dynamics area of consideration. The double-pointed arrow line which flows between supervision dynamics and the therapeutic relationship illustrates both (a) the interactive flow between supervision and supervisee and (b) the fact that supervision can have an impact on the overall decision-making process and the parties involved. Ethical decision making and boundaries of competence literature place an emphasis on supervision/consulting colleagues. However, discussion about the potential influence and impact of positive, indistinct, and/or negative dynamics within the body of ethics literature is comparatively rare.

The only model found in the literature which encourages counselors to evaluate the influence of supervision on the decision-making process is the feminist model (Hill et al., 1995). Hill et al. cautioned counselors to be aware of the influence "the consultant's values, conceptualizations of therapy, and relationship to the questioner are likely to have" (p. 27) on the decision-making process. Although this statement

does not fully match the ideas of supervision dynamics influencing the decision-making process as put forth in the emergent model, it is the most direct statement found in ethical decision-making literature acknowledging that supervisees need to evaluate the potential for supervisors to skew the decision-making process.

The impact of supervision on the parties involved in the therapeutic relationship is the second aspect of the flow that goes between supervision dynamics and the therapeutic relationship areas of consideration. None of the ethical decision-making models reviewed for this study speak to the potential impact of supervision on the parties involved. However, in her latest ethics text, Welfel (2006) stated that some types of negative supervision can traumatize supervisees. According to Welfel, supervisors have an ethical responsibility to protect client welfare. In contrast, the data, out of which the negative clinical guidance primary element emerged, revealed that supervisors negatively impact client welfare through negative supervision.

According to boundaries of competence literature, the models for ethical decision-making found in the literature, and the emergent model, seeking clinical guidance is an important part of the ethical decision-making process. However, none of the models for ethical decision making reviewed for this study use descriptors identifying quality of supervision or encouraged counselors to evaluate the supervision dynamics. Only Hill et al. (1995) encouraged counselors to evaluate the influence of supervision on the decision-making process. None of the models spoke to the potential impact of supervision on counselor and/or client. The emergent model for ethical decision making encourages counselors to evaluate the influence and impact of

supervision on the decision-making process, their clients as well as their own professional self and development.

System Dynamics Area of Consideration

Attending to and evaluating system dynamics is one of the five major areas of consideration in the emergent model. The idea that system dynamics are a factor in the decision-making process is sprinkled lightly through literature related to ethical decision making (Corey et al., 2003; Cottone, 2001, 2004; Cottone & Tarvydas, 2004; Garcia et al., 2003; Hansen and Goldberg, 1999; Koocher & Keith-Spiegel, 1998; Remley & Herlihy, 2005; Rest, 1984, 1994; Stadler, 1986; Tarvydas & Cottone, 1991; Welfel, 2006; Woody, 1990). The words "sprinkled lightly" are intended to convey the reality that although these authors have given some space to the notion of system dynamics, only Hansen and Goldberg have placed emphasis on the interplay between system dynamics and the ethical decision-making process. Tarvydas and Cottone pointed out that counselor decision-making processes are embedded in sociological and economic systems with "multiple and discrete levels of social influence" (p. 13) and, thus, highlighted the need for counselors to pay attention to the relationship between system dynamics and ethical decision making. Hansen and Goldberg recognized the influence and impact of economics on ethical decision making and recommended counselors review employment and insurance panel contracts carefully before beginning services.

The system dynamics component common to the ethical decision-making models reviewed for this study is summarized in Table 9 and involves consideration of the organizational context in which an ethical difficulty emerges. None of the major models reviewed in this chapter offered significant discussion or emphasis on system dynamics. Rest (1984, 1994) encouraged counselors to be mindful of temptations and/or pressures to protect one's organization. He warned that such temptations and pressures could lead to moral compromise. Remley & Herlihy (2005) included agency or institutional policies as a potential resource for counselors who are struggling with ethical concerns. Several of the secondary models reviewed for this study (Cottone, 2001, 2004; Garcia et al., 2003; Hanson & Goldberg, 1999; Stadler, 1986; Woody, 1990) made reference to organizational policies influencing the decision-making process. The secondary model presented by Hanson and Goldberg is the only model reviewed for this study that designated an entire element of their model to issues of organizational governance.

Negative and Positive System Dynamics Primary Elements

The emergent model highlights the need for counselors to be aware of the potential role negative and/or positive system dynamics can play in the decision-making process. Negative and positive system dynamics were defined earlier in this section. The overarching words participants used to describe negative systems were unresponsive, disruptive, chaotic, confusing, and disrespectful. The words participants used to reference positive systems were supportive, ordered, facilitation, responsive,

and considerate. Additionally, provision of and/or facilitating qualified supervision is considered an essential component of positive system dynamics.

Only a few references to the impact of negative system dynamics were found in ethics and ethical decision-making literature. According to Koocher and Keith-Spiegel (1998) the pressures within a given workplace environment may influence the erosion of sound ethical practice and/or create "overwhelming emotional distress" (p. 340) for the practicing professional counselor. Corey et al. (2003) recommended counselors take a proactive course of action when they find themselves in the midst of difficult system dynamics. This recommendation is in keeping with the ACA's (2005) code of ethics that states: "Counselors alert their employers to conditions that may be potentially disruptive or damaging to the counselor's professional responsibilities or that may limit their effectiveness" (Section D.1.c.).

Welfel (2002) discussed the benefits of working through an ethical dilemma in the context of positive system dynamics. According to Welfel, counselors working in settings that create a culture of high ethical standards will be more likely to experience positive reinforcement and support in situations requiring complex ethical decision making and less likely to encounter resistance to difficult, yet necessary, ethical choices.

System Dynamics Interactive, Influence, and Impact Flow Lines

The flow lines related to system dynamics in the emergent model demonstrate the influence and impact of system dynamics on the decision-making process and

parties involved. The two double-pointed arrow lines directly connect system dynamics to supervision dynamics and the therapeutic relationship area of consideration. However, the influence and impact of systems dynamics may carry through to the outcome and aftermath/post-outcome reflection areas of consideration. Consequently, the emergent model encourages counselors to assess the potential negative or positive impact of system dynamics on the decision-making process. Other than the references regarding system dynamics and ethical decision making, nothing was found in ethical decision-making literature referencing the influence and/or impact of system dynamics on the decision-making processes and parties involved. The contrast between the lack of attention to the system dynamics on ethical decision-making literature and the powerful data generated by participants in this study related to the influence and impact of systems on their decision-making processes and sense of professional self is remarkable.

The emergent model alerts counselors to the potential influence and impact of system dynamics on the ethical decision-making process. System dynamics in the emergent model is noteworthy enough to warrant a separate area of consideration. There is a significant difference between emphasis placed on the influence and impact of system dynamics in the models found in the literature and the emergent model. Although some of the models reviewed for this study indicate system dynamics may play a role in the decision-making process, only one (Hanson & Goldberg, 1999) places significant emphasis on this area of consideration.

Outcome Area of Consideration

Resolution is a natural expectation at the end of a decision-making process. Most of the ethical decision-making models reviewed for this study address selection and implementation of the selected action(s). The last two components listed in the action steps table (Table 10) in Chapter 2 illustrate the consensus that reaching resolution is an expected part of the decision-making process. On a structural level, there is a great deal of similarity between the models found in the literature and the emergent model. Both the models found in the literature and the emergent model set outcome as a significant part of the process. However, the emergent model leaves room for a larger number of outcome options than the models in the literature suggest.

Boundaries of competence specific literature offers two options for resolution of a boundaries of competence dilemma. They are continue treatment or termination and referral (Rinas & Clyne-Jackson, 1988; Welfel, 2002). However, participants in this study demonstrated that there is a wider set of options operative in everyday clinical life. Those options include continued treatment by the initial counselor, continued treatment by the initial counselor in combination with another therapist, termination and referral selected by the counselor, termination by the client initiated in some direct form by the client, and indirect termination by the client who simply does not return for treatment. This last option is referred to in the emergent model as client fading away. These options are grouped together in the *Outcome* content symbol within *Counselor Determination* and *Client Determination* primary elements shown in Figure 22.

Additionally, it should be noted that although ethics literature generally offers only two options (i.e. continued treatment or termination and referral), Remley and Herlihy (2005) listed creating a team approach as an additional continued treatment alternative. They suggested referring clients for work on the areas of concern to an expert in the area, while continuing to work with the client on other issues within the counselor's boundaries of competence. One participant in this study did create a team approach as resolution to her concern.

Counselor and Client Determination Outcome Primary Elements

Counselor-Determined Continued Treatment Secondary Element

Counselors may select continued treatment in a new practice domain as resolution for their boundaries of competence concern but they are ethically bound to follow the ethical standards set out in the codes for entering new specialty areas (Corey et al., 2003). Continued treatment is a viable option only if counselors do the work necessary to become competent in the designated new practice domain (Corey et al., 2003; Corey & Herlihy, 1996; Pope & Vasquez, 1991). The literature on new practice domains clearly outlines further training and supervision with professionals who have knowledge and experience in the area of concern as an essential part of a continued treatment plan or action (Pope & Vasquez: Rinas & Clyne-Jackson, 1988; Welfel; 2002). According to the codes of ethics for the ACA (2005), AAMFT (2001), and NASW (1999), mental health professionals are responsible to seek education, training, and supervised experience when entering new specialty areas of practice. The

APA (2002) ethics codes allow psychologists to provide services in new areas "if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study" (Section 2.01(d)).

The emergent model acknowledges continued treatment as an option for resolution and encourages adherence with ethics code guidelines concerning training and supervision when this option is selected. Four participants selected continued treatment, but only one of them sought out supervision specifically related to the issue of concern and none of them indicated they would seek out further formal training or even pursue independent reading in the area of concern.

The absence of adherence to the ethics codes concerning new practice domains is not actually as it appears. One participant decided on a team approach that relegated dealing with the issue of concern to the care of the second therapist. Another participant realized that the issue of concern was not a client issue but an issue she needed to address within herself. She indicated she would do that in her own therapy. The final participant presented a case that caused him caution about his competence. His plan was to continue treatment and assessment with the understanding that if he determined he was indeed beyond his competence, he would refer at that point. In spite of these circumstances and because of the absence of participant statements that acknowledged the need for further training and supervision, discussion of the elements within the emergent model includes consideration of new practice domains ethics codes and relevant literature that sets the standard for counselors to seek training and supervision when working beyond their understood competence.

Counselor-Determined Termination Secondary Elements

Counselor-directed termination is the second of the two options presented in boundaries of competence literature. Once the decision to terminate the process of counseling because of boundaries of competence concerns has been made, the counselor must attend to appropriate ethical procedures (Corey et al., 2003; Remley & Herlihy, 2005). According to the ethics codes relevant to mental health practitioners, ethical termination of a client who still needs counseling services must be accompanied by a referral process or counselors will be abandoning the client and thus be in violation of the codes (ACA, 2005; American Mental Health Counselors Association (AMHCA), 2000, National Board of Certified Counselors (NBCC), 2002; National Career Development Association (NCDA), 2003; CRCC, 2001; APA, 2002; NASW, 1999; AAFMT, 2001).

Literature related to termination and referral suggests several agreed-upon procedures related to the termination and referral process. First, counselors must make sure their suggestions for referrals have competence in the area of concern and would be interested in engaging with the particular client (Rinas and Clyne-Jackson, 1998). Second, counselors need to work with their clients in the process of making a transfer to another therapist (Barnett & Sanzone, 1997; Corey et al.; Halgin & Caron, 1991; Koocher and Keith-Spiegel, 1998; Leigh, 1999; Quintana and Holahan, 1992; Remley & Herlihy, 2005; Siebold; 1991). Third, counselors need to offer clients several sessions for purposes of closure and transferal (Remley & Herlihy). All three of these suggestions fall under working with the client flow line in the therapeutic relationship

area of consideration in the emergent model and are suggestions participants generally followed when approaching their clients about referral.

It has also been suggested that counselors have honest discussions with their clients about the concerns that generated the need for referral (Halgin & Caron; Remley & Herlihy). There is room in the emergent model for this step in the termination and referral process but with some cautions, as discussed elsewhere in this chapter.

Client-Determined Termination Secondary Element

The fact that clients may spontaneously self-terminate is not listed as a resolution option in boundaries of competence literature. However, it was the experience of five of the participants in this study. For two of these participants, client terminations led to difficult aftermath/post-outcome reflection dynamics. For this reason it is a factor for consideration in the decision-making process in this reality-based research model for ethical decision making.

Outcome Flow Line

There are two flow lines related to outcome. The first is the single-point arrow line flowing from the therapeutic relationship area of consideration to the outcome area of consideration. The second is also a single-point arrow line but this one flows from outcome to aftermath/post-outcome reflection. This second line is considered under the aftermath/post-outcome reflection area of consideration.

The line flowing up from the outcome area of consideration gathers a multitude of dynamics and factors as the action for resolution is selected and implemented by counselor and/or client. Table 10 in Chapter 2 summarizes the selection of action(s) and implementation of action(s) components as presented in the models found in the literature. The select action(s) component was discussed under the counselor response to concerns secondary element. Therefore, only the implement action(s) component will be discussed here. A number of models reviewed for this study designated implementation of the selected action as a significant factor in the decision-making process and set it up as a separate step in the process (Cohen & Cohen, 1999; Forester-Miller & Davis, 1996; Garcia et al., 2003; Hill et al., 1995; Rest, 1984, 1994; Stadler, 1986; Welfel, 2006). Although Corey et al. (2007), and Remley and Herlihy (2005) combine action selection and implementation, their presentations stress implementation is a significant component in the ethical decision-making process.

Within ethical decision-making models, the concept of moral courage or character is mentioned a number of times in relation to implementation of the selected action (Rest, 1984, 1994; Cohen and Cohen, 1999; Cohen and Cohen (1999), Forester-Miller and Davis, 1996; Remley and Herlihy, 2005). Cohen and Cohen argued that virtuous counselors are willing to carry out what they believe to be the right moral action choice in spite of indications that doing so may mean incurring potentially significant difficulties. Moral courage to implement ethically and clinically sound decisions is a factor emphasized in the emergent model. This emphasis emerges out of the data related to painful endings for both counselor and client.

Continued evaluation (Hill et al., 1995), attending to one's internal process including the influence of values and power differential factors (Hill et al.; Remley & Herlihy, 2005; Welfel, 2006), informing all relevant and appropriate parties (Welfel), possessing clinical skill (Haas & Malouf, 1995), and considering contextual factors (Hill et al., Garcia et al., 2003) are other notions relevant to implementation of selected actions. As participants reflected on their decision-making processes they reported considering, struggling with, or wishing they had understood some or all of these factors. These considerations are encouraged in the emergent model. However, this research-based model also recognizes that sometimes reality may not afford counselors such ideal and well-orchestrated implementation processes.

The outcome area of consideration is very similar to discussion of implementation of selected actions found in ethical decision-making models reviewed for this study. Encouragements for counselors to attend to sound ethical reasoning in the implementation of their selected actions for resolution is present in the emergent model and in the models of ethical decision making found in the literature. The major difference between the emergent model and models in the literature is the emergent models' addition of client-determined termination as a part of counselor consciousness about the potential spectrum of resolution options.

Aftermath/Post-Outcome Reflection Area of Consideration

Encouragement for counselors to engage in post-outcome reflection is found in

both the emergent model and models of ethical decision making found in the literature. However, as with some of the elements in the therapeutic relationship (the supervision dynamics, system dynamics, and outcome areas of consideration), there are some differences in emphasis and tone between the emergent model and models found in the literature.

In the emergent model, post-outcome reflection is a critical part of the decision-making process. Only the primary models of Hill et al. (1995) and Welfel (2006) devoted an entire step to what is typically referred to in the literature as post-decision reflection. The theory-based primary models of Hare (1984, 1994) and Kitchener (1984a, 2000), the practice-based models of Forester-Miller and Davis (1996), Remley and Herlihy (2005), and Corey et al. (2007), and all of the secondary models reviewed for this study ended the decision-making process with the implementation of the decision. However, for the 14 participants in this study, the decision-making process did not end with the implementation of the decision or outcome. All of them included in their story and conceptual map some information about what happened after the case had been resolved.

It should be noted that the primary modes of Forester-Miller and Davis (1996), Remley and Herlihy (2005), and Corey et al. (2007), as well as the secondary model presented by Stadler (1986), recommended post-decision actions that are included with the factors for consideration in the emergent model's aftermath/post-outcome reflection area of consideration. However, these are not included as an integral part of the decision-making process. A summary of the post-decision refection component as

presented in models of ethical decision making found in the literature and reviewed for this study is offered in Table 11.

Assess and Attend to Feeling Responses Related to Clinical and Decision-Making Process Primary Element

Counselors are encouraged to reflect on two aspects of the decision-making process within this primary element. The first aspect is assessment of the clinical and/or the ethical decision-making process. The second involves attending to post-outcome feelings. Each of these aspects may yield a sense of satisfaction and/or feelings of being unsatisfied or unsettled. Satisfied and unsatisfied/unsettled are the two secondary elements housed within this primary element. These secondary elements are like permeable containers participants used to identify their post-outcome assessments of the process and aftermath feelings.

Assessment is encouraged by Forester-Miller and Davis (1996). Although they did not recommend post-decision reflection, they did encourage counselors to follow up on the outcome(s), whenever possible, in order to assess the consequences and/or effectiveness of their action(s). There is little in ethical decision-making literature that speaks to assessment of the clinical process, but there are a few encouragements to assess the process in the course of attending to feeling responses.

Following resolution of the dilemma, Remley and Herlihy (2005) suggested "applying four self-tests" (p. 14) to reflect on the process. These four self-tests address justice, universality, publicity, and moral traces, and involve asking critical questions

in each of the areas. During this time of reflection counselors are encouraged to assess their actions, decisions, and interactions. Remley and Herlihy encouraged counselors to determine whether or not they would (a) apply the same actions, decisions, and interactions to other similar situations, (b) recommend the same course of action to colleagues, and (c) be willing to have their actions made public. Remley and Herlihy encouraged counselors to listen to any feelings that emerge around the decision and action as they work through these self-tests. They acknowledged that post-decision feelings may be uncomfortable, but insisted counselors allow their internal comfort or discomfort be embraced as preparation for future ethically demanding situations.

Beauchamp and Childress (2001) indicated moral traces are "appropriate and even expected in a person of good moral character" (p. 406). Stadler (1986) noted that feelings naturally emerge when counselors engage in difficult ethical decision-making processes having no clear right answer. The emergent model also recognizes that counselors may reflect back on the clinical and/or decision-making processes and experience feelings of satisfaction, dissatisfaction and/or a sense of unsettledness. Although the notion that counselors need to attend to potential unsettling post-outcome feeling responses is a point of similarity between the emergent model and models presented in mental health literature, aftermath/post-outcome feelings, as presented by the participants in this study, have an emotional energy beyond encouragements to attend to post-outcome reflection presented in the literature.

Growth Realized Primary Element

This primary element in the emergent model alerts counselors to the value of post-outcome reflection as a tool for growth and encourages them to engage in the process of assessment and reflection. Corey et al. (2007), Hill et al. (1995), Remley and Herlihy (2005), Stadler (1986), and Welfel (2006) all encouraged counselors to use post-resolution reflection as a means of learning and/or evaluation. Hill et al. (1995) asserted experience changes all parties involved in a given situation and contended that the use of reflection leads to increased self-knowledge and enriched future clinical work. Welfel boldly stated her belief that "experience without reflection is wasted" (p. 41). The literature on ethical decision-making and the emergent model both encourage post-outcome reflection as a means to enhance professional growth.

Aftermath/Post-Outcome Reflection Impact Flow Line

Each of the areas of consideration is connected to the whole of the decision-making process via flow lines. Aftermath/post-outcome reflection is no exception. The single-point arrow line flowing up from outcome to aftermath/post-outcome reflection is intended to represent the gathering of all the actions and dynamics that have taken place in the decision-making process and finally ended up impacting and/or influencing the counselor. None of the models of ethical decision making reviewed for this study talk so dynamically as this one flow line in the emergent model. Aftermath is a dramatic word, but a number of the participants told dramatic stories about the impact of their selected client cases on their own lives. In the emergent model

aftermath/post-outcome reflection is not another step in a multi-step check list, but a critical part of an integrated and interactive holistic process.

A comparison of the emergent model to models of ethical decision making found in the literature revealed similarities and differences. Nine factors were comparable enough to be designated the same in both the research and literature presented models. Another nine factors were found in both the emergent model and the models reviewed for this study, but the factor in the emergent model was in some way dynamically different. Six factors present in the emergent model were not found in ethical decision-making models reviewed for this study. Some of the dynamic differences and/or new factors are briefly mentioned in general ethics literature or may be present in other mental health literature (e.g. therapeutic skills, supervision, and/or community agency literature). However, those bodies of literature are beyond the scope of this study and, more importantly, are not addressed when counselors seek out guidance for decision making within the current models of decision making available in the literature.

DISCUSSION OF THE MODEL

The emergent model, which is the end result of this qualitative grounded-theory research study, is a model for ethical decision-making specific to boundaries of competence concerns. The model emerged from both transcribed interview and participant conceptual map data generated during the 14 face-to-face interviews with practicing licensed professional counselors in the state of Illinois. Expanded

discussion of the rationale behind the encouragements and/or cautions for counselor educators, supervisors, and counselors is presented in this section.

Discussion is structured around the major units for consideration in ethical decision-making, along with primary, secondary and tertiary elements, and flow lines that make up this non-linear interactive model. Breakdown of factors for discussion proceeds with the same divisions found in Table 35. The therapeutic relationship area of consideration discussion separates out two client and six counselor factors for discussion in sub-sections. These sub-sections vary slightly from secondary and tertiary element divisions in the conceptual map and model presentation sections of this chapter. Supervision dynamics, outcome and aftermath/post-outcome reflection areas of consideration discussions are divided according to primary element divisions. System dynamics is addressed as one unit. Discussion of each of the areas of consideration will address the interactive influence and/or impact represented by flow lines either under separate subheadings or integrated into the body of the discussion of relevant factors. Before considering the rationale for encouragements and cautions found in each of the areas of consideration, some discussion is offered about the interactive non-linear nature of the model.

Decision-Making Process Style: Interactive Non-Linear

Participant responses to boundaries of competence concerns that emerged from their selected client case examples give a glimpse into ethical decision-making patterns of practicing professional counselors. The overall style of decision making for

participants in this study can be seen in their conceptual maps and was generally illustrated as interactive and non-linear. A computer duplication of participant maps is presented in Chapter 4 (Figures 3 through 16). The terms interactive and non-linear overlap but are distinct. Non-linear indicates a process that does not move from point to point in a linear step-by-step manner. Interactions take place on two levels: (a) between counselor and client and between areas of consideration and the parties involved, and (b) within the counselor as she or he moves through the decision-making process. Interactive highlights the nature of the non-linear process.

The interactive non-linear nature of the emergent model is represented in Figure 22 with flow lines between areas of consideration and within the therapeutic relationship area of consideration. The power of participant stories was most often related to the influence and impact represented by these interactive flow lines. The interactive and impact flow lines connect the parts of the process into a whole. It is the interaction between supervision dynamics and system dynamics that often influenced and impacted the decision-making process, counselors, and clients. In the end, it was the interactions between client and counselor, supervisor and supervisee, system and therapeutic relationship that impacted and sometimes determined the aftermath/post-outcome reflections for participants. The dynamics and interactions represented by flow lines on the emergent model conceptual map yielded some of the most significant findings of the study. The significance of each of these interactive influences and impact flow lines will be discussed under the relevant area of consideration.

All but one participant demonstrated an interactive non-linear pattern of decision making. Although he did hint at some discomfort with the linear nature of his map, he also offered some information indicating that he is by nature a person who sees problem solving as a step-by-step linear process. It should be noted that, although this one participant demonstrated a linear processing style, it was still an interactive process. His external interactions moved back and forth between his supervisor and himself. He reported his internal process as one of back-and-forth considerations. He considered and reconsidered his own insights, his supervisor's instructions, and his client's ongoing presentation. The conclusions from the data about process style are: (a) ethical decision making is an externally and internally interactive process, and (b) practicing professional counselors generally process ethical decisions in a non-linear fashion, but there are exceptions to the rule.

The emergent model and current trends in literature related to ethical decision making affirm and/or promote an interactive non-linear decision-making style. The overall decision-making style of the participants in this study is very similar to the style presented by Hill et al. (1995). That is not to say that all counselors do or should think and work through ethical decisions using a pattern of interactive non-linear processing. It is to say that practicing professional counselors may generally be more inclined towards a relational/interactive, and non-linear decision-making style. Given the dominate demonstration of interactive non-linear decision-making patterns in this study, counselor educators and supervisors might find it advantageous to tap into that problem-solving style when training for clinical/ethical decision making and/or

supervising counselors who are struggling through complex ethical decision-making situations. Additionally, the data indicate that counselors also need to be encouraged and trained to see the decision-making process at the two interactive on two levels described at the beginning of this section. This training for the reality of what they will encounter in the field may help normalize the complex and often daunting process of complex decision making.

Therapeutic Relationship Area of Consideration

The therapeutic relationship area of consideration is the core of the emergent model and unique to ethical decision-making models but not to the overall body of ethics literature. The therapeutic relationship is the starting point or beginning of the model and the area of consideration through and/or out of which all other areas flow. The influence and impact of these various interactions, which flow between the counselor and client and/or therapeutic relationship and other areas of consideration, will be discussed within pertinent areas of consideration. The emergent model encourages counselors to attend to the influence and impact interactive dynamics have on the ethical decision-making process. Counselors may experience and/or assess these dynamics as positive, neutral, or negative. Regardless of the nature of the dynamics, the emergent model alerts counselors to attend to the reality that interactive dynamics have the potential to skew the process of decision making.

Client Dynamics

Participants wove client dynamics into each of their stories of decision making and spoke of client dynamics as inseparably linked to counselor dynamics within the therapeutic relationship. There are two aspects, which are divided into two secondary elements, associated with client dynamics in the emergent model. The first is client background and the second is consideration of the impact client presentation and approach to treatment has on the decision-making process. Models of decision making found in the literature do include the concepts that make up client background considerations. However, none of them bundle client background into an overall dynamic that alerts counselors to attend to the dynamics between counselor and client as a potential factor in the ethical decision-making process, nor do they encourage counselors to note the influence client presentation and approach to treatment might have on the decision-making process. In the emergent model counselors are encouraged to attend to client dynamics and the interplay between client and counselor.

Client Background

Participants in this study modeled respect for client dignity. Even in the midst of emotional explanations of very challenging situations participants wove a sense of respect, a desire to protect client dignity, and contextual sensitivity into their stories of decision making. Consistent with data collected for this study and ethics literature, the emergent model encourages counselors to attend to client background in a way that

respects client dignity and is contextually sensitive. The two sub-factors or tertiary elements within this secondary element, labeled *dignity* and *context* in Figure 22, are consistent with ethics codes mandates, general ethics literature, and considerations referenced in several ethical decision-making models found in the literature.

Client background may seem to be such a fundamental part of the overall therapeutic process and/or relationship that it is unnecessary to include it as a factor in ethical decision making. However, analysis of the data pointed not only to the inclusion of this element as a factor, but also demonstrated that it is a fundamental consideration in the decision-making process. All participants wove client background and context consideration throughout their stories of the decision-making process. Participant maps highlighted background information and client concerns more consistently than in any other area. Every participant map included at least one content symbol designated to background material and/or material enumerating client life context considerations as part of their decision-making processes. Six participants created two content symbols related to this sub-sub-category and one created three. Therefore, attending to client background and having a conscious awareness of how client background influences decision-making is a stated consideration in the emergent model.

In ethics literature, client context is sometimes referred to as contextual sensitivity and linked to multicultural competencies, which includes issues of diversity. In the same way that the models presented in the literature seem to presuppose adherence to the standards set forth in professional codes of ethics, the

emergent model presupposes counselors have some knowledge of multicultural dynamics and adhere to the standards of the codes set forth for multicultural counseling situations. Counselors attending to both their own and their client's values is a part of this step in the decision-making process encouraged by the emergent model and several models found in the literature (Corey et al., 2007; Hill et al., 1995; Remley & Herlihy, 2005).

Although participants in this study identified only a couple of situations falling clearly under multicultural competence considerations, those cases were presented with a stated sensitivity to client context. The consideration of the client context factor in the emergent model leaves generous space for counselors to attend to multicultural dynamics at all points of the decision-making process. The model is applicable to multicultural situations because of the emphasis on consideration of client background, as well as client presentation and approach to the therapeutic process that flows through the entire decision-making process. These factors, when informed by multicultural competence, make the emergent model a comfortable fit in multicultural situations.

The fact that 14 practicing professional counselors generated data consistent with the professional priorities of protecting client dignity in a contextually sensitive manner provides a measure of encouragement for counselor educators and other leaders in the field of counseling. Extending dignity and giving overt attention to clients in ordered environments, while experiencing positive clinical guidance, with clients who have the ability and disposition to work the process, and when presenting

issues are such that goal setting and attainment is within easy reach is perhaps a normative expectation for trained professional counselors. However, a number of these participants reported working in confusing and/or conflicting environments, experienced conflicted or unhealthy supervision dynamics, spoke about clients resisting treatment interventions and/or presented circumstances that are generally considered difficult. In spite of these challenging clinical dynamics, participants spoke of their clients with a remarkable sense of grace, human kindness, and contextual sensitivity.

The Impact of Client Presentation and Approach to Treatment

According to data collected for this study, the dynamics of client presentation and/or the manner in which clients approach the treatment process influences the decision-making process. Participants presented a range of client scenarios. Some of the clients were eager to engage in the process and others were resistant. Some could not or did not effectively use counselor interventions and others took the interventions and worked well with them. Some were unable to respectfully respond to therapeutic boundaries and others were relationally appropriate. These are just a few of the different client presentations and approaches to treatment reported by participants, and participants indicated that they all in some way influenced the decision-making process.

Although this was a critical factor in client situations presented by participants and clearly influenced decision-making, no mention is made of it in the ethical

decision-making models found in the literature. Some participants reported this factor with stated consciousness about the impact client presentation and/or approach had on the process. Other participants presented data that showed this factor as an influence on the process, but the participants themselves gave no indication about having a conscious understanding about client dynamics impacting the process as they were going through the process.

In the emergent model counselors are alerted to the fact that client presentation and approach to treatment can influence decision making and are encouraged to attend to this dynamic in their clinical practice of professional counseling. Because the data for this study indicates that the decision-making process is influenced by client presentation and approach to treatment, the emergent model has added this factor for consideration in ethical decision-making processes. This factor has implications for training and supervision. It implies that counselor educators need to prepare counselors to be aware of the influence of client dynamics on the decision-making process. The addition of this factor to ethical decision-making models also implies that supervisors need to keep a watchful eye for how the decision-making process is being skewed by client dynamics and guide supervisees accordingly.

Counselor Dynamics

All six of the sub-elements addressed within counselor dynamics are present to one degree or another in models reviewed for this study. However, as with client dynamics, the various elements and factors of counselor dynamics as factors for

consideration in ethical decision-making models found in the literature are not bundled into an overall dynamic influencing the decision-making process. Additionally, two of the elements (i.e., awareness of concern[s] and counselor actions/strategies) are in some way dynamically different from these factors as found in the literature. Therefore, although there is significant overlap between the counselor dynamics considerations and the factors to consider in the ethical decision-making process put forth in ethics literature, it was decided to show counselor dynamics in Table 35 as having a dynamic difference from the literature and being neither the same nor being an added factor.

Counselor as Professional

Professional training and development provides the foundations for ethical decision making in clinical settings. Participants in this study referenced their training and development as foundational in identifying their stated ethical dilemmas and understanding the need for resolution to their concerns. They each brought their sense of trained professional self to the process. None of the models for decision making found in the literature overtly include the sense of professional self, but consideration is given to this element in the material surrounding model presentations (Corey et al., 2007; Remley & Herlihy, 2005; Welfel, 2006).

Some participants reported a strong sense of adequacy for the tasks of decision-making and the consequent interventions that would be required. Others indicated that they felt inadequate to manage the dynamics they had encountered in their selected

case scenarios. One participant spoke of not knowing, at the time of her selected case example, that as a professional counselor she had power. She believed that if she had understood this piece, she could have advocated for her client and seen a different and more desirable outcome. Another participant looked back on his experience as a novice counselor surrounded by chaotic supervision and system dynamics and remarked about how differently he saw things at the time of the interview that occurred years later. The selected case had occurred during his novice years. In the intervening years he had intentionally pursued professional development opportunities. He didn't seem to know what he would have done differently given the historical context of his selected case example and acknowledging his own sense of being a novice clinician who just didn't know what to do, but he was clear that as an experienced counselor he consciously brought supervision to his supervisees that was significantly different from what he had received. At the time of the interview he was clinical director for a county agency. He demonstrated a professional maturity and spoke of having developed a sense of professional self that would not allow the agency or any supervisors, including himself, to create harmful supervision dynamics.

In the emergent model counselors are encouraged to assess their own professional training and development levels. Participants in this study demonstrated that knowing strengths can build confidence, which is often needed for decision-making tasks. Some participants indicated that clearly understanding their areas of weakness would have made a difference. It is assumed that the ethical counselor who

senses an area of weakness will actively seek resources to assist with finding and implementing ethically sound resolutions.

Counselor Virtue

Counselors are human and bring to clinical and ethical decision-making processes their own personal selves. The person of the counselor, addressed in the emergent model, includes counselor virtue or character and counselor feelings. Counselor character in the emergent model is organized around the virtues of prudence, integrity, respectfulness, trustworthiness, and compassion. These virtues are discussed in Chapter 2, and data related to participant demonstration or lack of demonstration of these virtues is listed in Chapter 5. Ethics literature in general, ethical decision-making models found in the literature, and the emergent model address the need for counselors to be virtuous. The emergent model is in harmony with the literature in encouraging counselors to assess their character in the process of decision making, and to be mindful of the impact their virtue or lack of virtue has on individual decision-making processes.

The data collected in this study specifically highlights a need for counselors to develop and live out the virtue of integrity. One of the most difficult stories of undesirable and painful outcomes was told by the one participant who did not demonstrate virtuous character. Meara et al. (1996) pointed out that to be lacking in integrity is equal to lacking in competence, because integrity requires that one's commitment to doing what is morally best remain consistent and unwavering even

under pressure or adversity. However, it should be noted that Meara et al. and Beauchamp and Childress (2001) have suggested there is some room for reasoned compromise when principles conflict with particular cultural groups in specific situations. Compatibility between the emergent model and multicultural sensitivity requires understanding that there is a fine line between integrity and rigidity.

Impact of Counselor Feeling Responses on Decision-Making Process

Participants in this study demonstrated that emotions play a role in the clinical interactions and counselor ethical decision-making processes. Encouraging counselors to attend to their own feeling responses during the decision-making process is part of the emergent model and consistent with cautions in general ethics literature (Corey et al., 2003; Koocher & Keith-Spiegel, 1998; Rest, 1984, 1994; Van Hoose & Kottler, 1988). According to Leigh (1988) this is specifically necessary during the implementation of a referral. In its encouragement to attend to feeling responses the emergent model is quite parallel to the feminist model of Hill et al. (1995).

Counselor Awareness of Concern(s)

What the emergent model speaks of as becoming aware of boundaries of competency concerns, is described as identifying and clarifying in models of ethical decision making found in the literature. These concepts essentially encourage counselors to recognize and get clear about the concerns needing to be addressed. The difference is that in the literature, the concept is presented as an event and in the

emergent model it is referred to as potentially either an event or a process. In all fairness, it should be acknowledged that authors of models found in the literature did not intend to exclude the possibility of identification as a process.

It is unmistakable from the data gathered in this study that awareness and clarity about a given concern may happen in an instant or in a series of clinical events that make the process appear like the dawning of a realization. Participants reported clarification as being equal to the degree of awareness they had about the concern at a given point in the process. Participants also demonstrated that awareness and clarity can occur at any number of points in the clinical process, whether a point-in-time event or a slow process of increasing clarity. Recognition that identification ranges from a point-in-time realization to a slow and subtle process of growing awareness is foundational to a complete understanding of this factor in the emergent model. Adding this dynamic to thinking about ethical decision making may assist counselors to more efficiently, and completely, attend to clinical dynamics that are not shouting at them but presenting subtly.

Response to Concerns: Utilization of Professional Resources

The emergent model alerts counselors to the need for and encourages them to utilize professional resources including professional regulations, ethics codes, relevant literature, professional organizations, and colleagues. These are steps also encouraged in ethics literature and ethical decision-making models found in the literature. Consulting colleagues or seeking supervision, as mentioned earlier in this chapter, is

separated out into its own area of consideration, and therefore, is not included in this discussion.

Utilization of professional resources is perhaps the weakest factor for ethical decision making reported by participants in this study. Participants reported engaging in an abundance of continuing education activities but did not report seeking out or engaging in issue specific reading, workshops, seminars, or further academic training in addressing their concerns with selected clients. It is also notable that none of the four participants who selected to continue treatment gave any indication that they had or intended to seek additional training for their work with selected clients.

Research relevant literature, seek continuing education, reference ethics codes and consult professional regulations. Ethics literature and ethical decision-making models found in the literature stress the need for counselors to research relevant literature, reference ethics codes, and consult professional regulations when engaging in complex ethical decision-making processes. According to ethics literature in general, literature specific to boundaries of competence concerns, and professional ethics codes, reading relevant literature and seeking out pertinent continuing education opportunities is a requirement for counselors entering into new practice domains. Although several of the participants indicated that independent reading was a valuable professional growth exercise they practiced, only two of the participants reported referencing relevant literature during the course of their decision-making processes. All participants engaged in continuing education experiences and reported these as valuable, but none of the participants reported seeking or engaging in continuing

education opportunities as a part of their reported decision-making processes. Participants presented themselves as having a general knowledge of ethics codes and professional regulations, but none of them reported consulting either source of professional information while working through their concerns.

New practice domains. It is only equitable to note that none of the four participants who selected continued treatment as resolution were clear-cut examples of continued treatment equaling entering new domains. One of the four, Suzy, happened upon a team approach and the area of concern, which would have been a new practice domain, was then handled by the second therapist. The second participant, June, decided, during the course of the research interview, that her concern was not an issue of competence but one of her squeamishness and countertransference. Her decision was to work with her own material in therapy. The third participant, Sally, encountered two concerns. The first was a point-in-time circumstance that required immediate resolution. She needed to act in the moment, did so, consulted her supervisor about the matter before the next session, and was affirmed in her selected course of action. There was never a question of referral involved. Her second concern involved a new treatment modality for which she was in training. She did some consulting with a former supervisor, and decided to continue to offer the treatment modality, but, in the end, her client selected not to take advantage of the innovative treatment intervention technique. The fourth, Bill, who was the fourth and final participant selecting continued treatment, decided to do further assessments while

continuing treatment. He resolved that if, after the next level of assessment, he still felt over his head, he would terminate and refer.

It can be easily understood that none of these participants were technically engaging in new practice domains. Therefore, they were not, strictly speaking, functioning outside of the ethics code mandates for supervision and training when entering new areas of practice. However, there are some clinical questions that arise around three of these situations.

Suzy's resolution of engaging another therapist and using a team approach does lessen the need for her to be clinically skilled with the issues she was concerned about. Suzy had no training in abuse and did not have a grasp of the dynamics of abuse that might impact the other pieces of therapy she was engaged in with her client. Additionally, it is of concern that Suzy's supervisor, who was consulted regularly about the continued treatment, never encouraged Suzy to read about child abuse or suggest she attend a workshop.

June's decision to work on her countertransference issues is certainly professionally noble. The selected client was concerned about becoming a perpetrator. June reported having a significant amount of knowledge about abuse victim dynamics and intervention strategies. She, however, indicated not knowing anything about perpetrator dynamics or treatment and also was clear that she was not interested in ever treating abusers. However, since her client was fearful of being an abuser, it would seem only logical that a workshop or some independent reading would be a

sound investment in the course of continued treatment with her selected client. June was not engaged in supervision and did not feel a need for consultation with this case.

Bill's concern was, in large part, about the level of depression his client was experiencing. Throughout the interview Bill repeated his self-assessment that he was not knowledgeable about clinical depression. He was in regular supervision and reported staffing this case with his supervisor on a number of occasions. According to Bill's report, his supervisor's interventions were very direct and instructive, but did not include instruction to engage in reading relevant literature or seek out continued education opportunities about clinical depression.

The emergent model follows ethical guidelines requiring counselors to seek supervision and training when engaging in new practice domains. Additionally, the three resolutions for continued treatment situations reviewed above suggest that counselors and supervisors might be well advised to attend to the ethics standards around entering new practice domains even when it appears the new practice domain is or may be rationally taken out of the immediate path of treatment. The lack of supervisor encouragement to research relevant literature and/or seek out continuing education opportunities is a concern that emerges because it is absent in the data and dominate in the relevant literature. Perhaps "practice domain" should be evaluated based on general foundational competence. The question that arises is, can a therapist be competent in the twenty-first century if she or he does not acquire clinical competence in the areas like depression and abuse?

Utilization of services offered by professional organizations. The emergent model encourages counselors to consult with their professional organizations after they have exhausted all other resources. Although ethics texts (Corey et al. 2007; Remley & Herlihy, 2005; Welfel, 2005) explain the value and power of professional organizations, Welfel was the only reference in which encouragement for counselors to turn to their professional organizations for legal and/or ethics direction was found. Only one participant in this study consulted a professional organization. However, this action was taken only after resolution had been forced upon him and his client by the system in which the case was embedded. What is remarkable about the data related to utilization of services offered by professional organizations is its absence. This lack of data coupled with the stress on the value and importance of professional organizations found in ethics texts makes the paucity of encouragement for counselors to consult with their professional organizations about ethical and legal issues perplexing and raised a question for this researcher: do professional organizations encourage this use of their services?

A search of the ACA website did not give a definitive answer to the question. However, an email exchange with L. Freeman, who is ethics and professional standards manager for ACA, clarified the availability of legal and/or ethics assistance through ACA and affirmed that ACA does encourage members to consult them about legal and ethical concerns. Freeman edited my comments and returned the following statement via email:

> After all other resources have been exhausted ACA members are encouraged to contact their National Headquarters' Ethics and Professional Standards

> Department for ethical consultation and legal referrals. They can expect to receive assistance that will help them determine the appropriate next step and/or inform them about significant parameters related to their dilemma. (personal communication, September 12, 2006)

The emergent model encourages counselors to follow guidelines outlined by Freeman and utilize ethical and legal services of their professional organizations, most notably the services available for ACA members.

Analysis of the data generated during the face-to-face interviews conducted for this study suggest that counselors are not utilizing professional resources in the process of ethical decision making. It is clear from the data that counselors have some knowledge of professional ethics code standards, engage in professionally related independent reading, and participate in continuing education opportunities. They report valuing independent reading and profit from continuing education experiences. However, they do not appear to link these activities to their ethical decision-making processes. The implication for counselor educators and supervisors is that counselors in training and supervisees need more direction in the area of applying teachings about these activities to ethical decision making. Additionally, counselor educators, supervisors, and professional organization personnel need to alert counselors to the availability of counsel when they have exhausted all other resources.

Response to Concerns: Actions and Strategies

As was stated in the literature comparison section of this chapter, the four action steps presented in models for ethical decision making found in the literature were present in the stories of decision making presented by participants. The four action

steps presented in the literature are generating possible actions, considering outcomes, selecting action(s), and implementing action(s). The first three are housed in the actions and strategies tertiary element. Implementing action(s) is represented by a flow line which moves from the therapeutic relationship area of consideration to the outcome area of consideration and is discussed under outcome. These steps in the literature are set out in a nicely ordered fashion, but participant data demonstrate them to be inseparable pieces of a dynamic multilayer web.

Corey et al. (2007) recommended constructing a variety of options and encouraged counselors to engage in brainstorming as a method of generating possible options. They suggested that brainstorming may even "help identify a possibility that is unorthodox but useful" (p. 22). Although participants in this study did not identify their efforts to generate solutions to their concerns as brainstorming, several did move through the decision-making process in what could be seen as a time-delayed brainstorming. They thought of a solution, tried it or dismissed it, processed another intervention strategy, and so forth until a resolution was reached.

The emergent model, in keeping with the literature about diversity considerations and factors that play out in rural counseling settings (Welfel, 2006), encourages counselors to assess realistic options while considering socio-economic factors, diversity, and geographic location factors and/or limitations. Counselors who select to continue treatment in boundaries of competence situations are encouraged to research the literature related to competence concerns in rural settings and reference professional codes concerning related to new practice domains.

The literature is clear about the need for considering the possible impact various possible actions might have on a client and their social support systems (Corey et al., 2007; Forester-Miller & Davis, 1996; Garcia et al., 2003; Haas & Malouf, 1995; Hill et al., 1995; Mattison, 2000; Remley & Herlihy, 2005; Rest, 1984, 1994; Stadler, 1996; Welfel, 2006). Rest (1994) included the evaluation process of potential actions as part of moral sensitivity, stating that moral sensitivity includes "knowing cause-consequence chains of events in the real world" (p. 23). Some of the participants reported that they had felt concerned about the impact termination and referral might have on their clients. However, the ruminations about this outcome impact reported by participants did not consistently, from participant to participant, have the depth of thought suggested in the literature. The data suggest that counselor educators and supervisors might consider the need for training and supervision interventions that will assist counselors in training and/or supervisees to more deeply contemplate the impact counselor termination and referral may have on a given client and/or their social support systems.

Selecting action(s), like generating possible actions, for the participants in this study was another area that did not occur as a step in the process but was reported frequently as a process of trial and error or try and try again. Selecting action(s) overlaps with implementing action. For those participants who reported counselor-directed outcomes, selection of that last intervention and implementation are one continuous movement. One of the striking pieces which emerged from the data is that counselors do not do action steps in a neat and tidy manner. The data led to the

conclusion that action steps are a multilayered web of considerations, decisions, and interventions.

Therapeutic Relationship Flow Lines

Flow lines within the therapeutic relationship area of consideration represent client and counselor dynamics that form the relationship aspect of the therapeutic contract. Models of decision making found in the literature include consideration of client background, application of moral principles, and encouragements to work with the client around concerns. However, none of the models reviewed for this study bundle client/counselor dynamics into an overall dynamic alerting counselors to attend to the dynamics of the therapeutic relationship as a potential factor in ethical decision-making. Attending to the therapeutic alliance is also not addressed in ethical decision-making models found in the literature. The emergent model incorporates all of these factors because participants in this study reported them as influences on their decision-making processes. Consequently, the emergent model encourages counselors to attend to client dynamics, counselor dynamics, and the interplay between client and counselor.

There are three flow lines contained within the therapeutic relationship area of considerations as illustrated in Figure 22. They are working alliance, counselor regard for the client: considering moral principles, and working with the client.

Working Alliance

Neither ethics literature in general, nor the ethical decision-making models reviewed for this study, referenced the working alliance as a factor for consideration in ethical decision-making. However, the data collected for this study suggest that the absence of a working alliance affects outcome. According to Egan (1998), the therapeutic relationship is collaborative. Egan further pointed out that "Helping is a two-person *team* effort in which helpers need to do their part and clients theirs. If either party refuses to play or plays incompetently, then the enterprise can fail" (p. 41).

Only three participants directly or formally referred to the therapeutic relationship, bond, or alliance as part of their ethical decision-making processes. However, the reality that the presence or absence of a working alliance influenced the decision-making process was clear in the data. Four of the participants selected clients with whom they did not have a working alliance. In each of these cases, the outcome was a client-determined termination. Perhaps this is illustrative of the failed enterprise Egan (1998) pointed out would occur if both parties were not engaged in the team effort. The emergent model encourages counselors to be aware of the presence or absence of a working alliance during the ethical decision-making process. The model alerts counselors to the potential impact the lack of a working alliance can have on outcome. Egan's warnings, taken in the context of competence and the need for ethical decision making, suggest that the absence of a working alliance is reason for assessing competence and, depending on the assessment results, entering an ethical decision-making process.

Counselor Regard for the Client: Considering Moral Principles

The emergent model uses the generally understood moral principles of autonomy, nonmaleficence, beneficence, justice, and fidelity to structure the discussion around counselor regard for the client. General ethics literature, the models for ethical decision making, and the emergent model all encourage counselors to understand and apply these moral principles in the practice of counseling and in ethical decision making. Analysis of the data collected for this study revealed that participants lived out application of the moral principles encouraged in mental-health literature. No participant used any of the formal names designated for moral principles, but there was reference to the concepts contained within each of the principles as participants told their stories of decision making. Participants wove into the entirety of their stories regard for clients that demonstrated respect for the individual choices, freedom and dignity, communicated a deep desire to do good and not harm, worked at being fair and equitable, and demonstrated faithfulness to their professional commitments within the client relationship.

Working with the Client

The emergent model encourages counselors to work with their clients to reach resolution for the identified concern except when clinical judgment indicates otherwise. Working with the client includes counselors sharing their identified concern and engaging client interaction around generating possible solutions, discussing possible impact of various solutions, and selecting the best action. The models of Hill

et al. (1995), Remley and Herlihy (2005), and Corey et al. (2007) all encourage counselors to work with clients around the area of concern. However, none of these models include the phrase except when clinical judgment indicates otherwise.

Three participants attempted to work with clients around their concerns, but reported that clients took control and implemented termination on their own terms. These client-directed terminations did not allow for healthy closure and/or referrals for further treatment options. Three other participants reported positive experiences related to working with clients around boundaries of competence concerns. Four participants were in situations in which the system influenced and/or directed participant actions, selection of resolution, and/or implementation of resolution so that there was little or no opportunity to work with clients around some aspects of the reported concerns. However, one acknowledged that he could have done more to work with his client. The resolution in this particular case was reported as very negative for both client and counselor, and the participant indicated, in hindsight, he could see that working with the client might have lessened the negative outcome dynamics.

The final four participants chose not to identify their concerns with their clients and/or not to work with them towards resolution. One reported positive feelings about her counselor-initiated termination and referral. One experienced a client-directed termination that was difficult because of the self-questioning that followed the lack of closure. Two selected continued treatment as resolution. June did not share her concerns with her client and spoke directly about her belief in the clinical wisdom of that decision. She said,

> I know that it is said out there that you need to be honest about [such things], but I've found that sometimes you don't have to be totally honest. If she knew about my dilemma, she would not be able to talk [and do her work].

The emergent model parallels models found in the literature in encouraging counselors to work with clients around identified concerns. However, the data, which formed this model, suggest there might be a need for counselors to use clinical judgment and skilled intervention techniques in application of this encouragement. The data demonstrate that practicing professional counselors do not always share their concerns with clients and, at least in one case, a rationale for that exception is given. Participants also generated data that indicate counselors are not always in control of results and sometimes do not have the opportunity to work with the client around identified concerns and/or good clinical resolution for both client and counselor. Additionally, there were mixed results for those who did share their concerns with clients. One is left to wonder if the mixed results are simply idiosyncratic client responses, or if counselors need additional training in working with clients around boundaries of competence concern issues. Further research around counselor intervention skills in applying encouragements to work with clients in boundaries of concern situations is suggested as a means of answering this question.

The therapeutic area of consideration in the emergent model is a very complex makeup of counselor and client dynamics influenced by numerous factors. Some of the factors for consideration in this area of consideration are compatible with, and even affirm, components of ethical decision-making models found in the literature (i.e. client background, counselor as professional, counselor virtue, counselor feeling

responses, use of professional resource, and consideration of moral principles). Other factors are parallel to the literature, but the data demonstrate additional or differing dynamics (i.e. awareness of concern, actions/strategies, and working with the client). The remaining factors (i.e. client presentation and approach to treatment and attending to the working alliance) actually are additions to the encouragements and factors for consideration presented in the ethical decision-making models found in the literature.

The therapeutic relationship area of consideration, as well as the client and counselor dynamics primary elements, differ from any of the considerations found in the models reviewed for this study. Each of these major units has sub-elements found either in general ethics literature or ethical decision-making models literature. However, there are significant dynamics present within participant reports of their decision-making processes that are not evident in the literature. Some of these dynamics, which are missing in the literature, were reported as significant factors influencing and/or impacting participant decision-making process. A summary of these results is given in Table 35.

Supervision Dynamics Area of Consideration

Ethical decision-making models found in the literature and the emergent model stress the importance of consulting colleagues during the decision-making process. Although supervision is encouraged in both the models found in the literature and the emergent model, there is an added dynamic in the area of supervision within the emergent model. This added dynamic encourages counselors to attend to the quality of

supervision and the potential impact supervision may have on the decision-making process. Discussion of the supervision dynamics area of consideration is divided into two sections: (a) encouragement to consult colleagues and (b) encouragement to evaluate and attend to the potential influence and impact of supervision dynamics on the decision-making process.

Encouragement to Consult Colleagues

Participants generated a significant volume of data related to seeking clinical guidance. They reported seeking out formal supervisor-led individual and group supervision, as well as informal peer networking, which was either group or individual consultation, for clinical guidance. Only one participant reported seeking no clinical guidance with her selected client case, but it is noteworthy that she appeared to use the research interview as a form of consultation. She did reach a decision for resolution during the interview. These data affirm the importance participants placed on seeking clinical guidance in the process of decision making and support the stress on supervision found in the literature with field research data related to boundaries of competence concerns decision making.

Evaluate and Attend to the Potential Influence and Impact of Supervision Dynamics

The data collected for this study demonstrate that when counselors engage in supervision, the interactions and dynamics created within the supervision experience can significantly impact the decision-making process and the parties involved. Positive

supervision led to reports of positive results, including stimulating professional growth and satisfaction with the ethical decision-making process. Negative supervision led to negative results, including potentially endangering clients, risking a negative outcome, and creating a painful aftermath/post-outcome reflection process for the counselor. Although participants did not report perceiving indistinct clinical guidance experiences as impacting the decision-making process in either harmful or helpful ways, the impact of indistinct supervision is evident in the data. However, participants stated that they wanted supervision to provide them with instruction, direction, challenge, and affirmation. Indistinct supervision provided little of these elements, and thus, it can be concluded that indistinct supervision does impact the decision-making process by creating a vacuum of guidance.

Based on the stories of supervision dynamics' impact on both the decision-making process and counselor sense of self, evaluation of supervision dynamics is considered central to the use of supervision. All three participants who reported positive clinical guidance experiences exhibited a positive sense of professional self that was reported as directly related to their supervision experiences. Each of them made statements linking their positive experiences to positive supervision. Among participants reporting indistinct clinical guidance experiences, there is a mixed presentation around an expressed sense of professional self and demonstrated commitment to professional growth. Seven of the eight participants in the indistinct group reported a sense of satisfaction with clinical process and outcome. The eighth participant is absent from this data set because he came to his resolution for outcome

during the face-to-face interview and did not report outcome or aftermath/post-outcome data. The most significant observation about the indistinct clinical guidance experiences reported by participants may be that, although it was not be reported as harmful, it is not linked to positive professional growth. It was bland and did not fulfill the normally understood expectations of supervision and/or clinical guidance. The three participants reporting negative supervision experiences told stories of pain and confusion. They were distressed about outcome dynamics for their clients and distressed about their own inability to effect positive change in the systems they worked in and/or for the clients they cared about. Participant data related to positive, indistinct, and negative supervision dynamics and their impact on the decision-making process are reported in detail in Chapter 5.

In the emergent model supervision dynamics are an important factor in the ethical decision-making process and consideration is given to the dynamic impact of the selected clinical guidance experience on the decision-making process and the parties involved. Counselors are encouraged to assess and attend to the supervision dynamics during the decision-making process. The only parallel to this encouragement in the models of ethical decision making reviewed for this study is found in the feminist model of Hill et al. (1995). Within the feminist model, counselors are also encouraged to attend to their own values, and they are instructed to consider supervisor values that may influence the decision-making process. Hill et al. are the only authors of decision-making models found in the literature who speak even slightly to the need for evaluation of supervisor values. No authors of ethical decision-

making models found in the literature address the need to attend to the potential impact of negative supervision dynamics on the decision-making process. For these reasons, this factor is seen as an addition to the literature on ethical decision-making models.

System Dynamics Area of Consideration

Participant data in this study demonstrated that supervision dynamics and system dynamics can combine to form a picture of potentially powerful influence and impact on the decision-making process and parties involved. Three participants told stories of negative system dynamics that significantly impacted their client cases and decision-making processes. It is out of one of these cases that the aftermath portion of the post-outcome reflection area of consideration emerged. All of these participants expressed significant pain and conflict around the system dynamics surrounding their selected client cases. As pointed out in the literature comparison section of this chapter, none of the primary models of ethical decision making reviewed for this study emphasize system dynamics as a factor, influence, or impact in clinical decision making. The models of decision making found in the literature do contain a light sprinkling of information about systems, but there is no significant discussion of system dynamics within ethics literature. Therefore, it is assumed that the emergent model is the first model to incorporate encouragement for counselors to evaluate and attend to system dynamics within the ethical decision-making process.

If it is true that to be forewarned is to be forearmed, then knowing the potential power and impact supervision and system dynamics and interactions can have on the decision-making process and parties involved, can be immensely valuable to counselors in training. Knowing ahead of time the kind of dynamic other counselors have experienced could, at the very least, reduce stress by normalizing the often cumbersome and tortuous decision-making process. Additionally, advance warning can increase counselor awareness and cognitive skill development in preparation for the real-life logistical demands when difficult ethical situations are encountered. Therefore, one implication of this study is that counselors in training will benefit from being exposed to the potential impact of supervision and system dynamics on the decision-making process and assist them developing problem-solving skills.

Outcome Area of Consideration

All participant responses to their boundaries of competence concerns generated data related to outcome. The complex and multifaceted nature of outcome data generated by participants was interesting and informative. Outcome data divided into two sub-categories that formed the two primary outcome elements in the emergent model. Counselor-directed continued treatment or termination and referral decisions make up the first element. Client-directed terminations make up the second element.

Nine participants reported counselor-directed outcomes. Five participants reported client-directed outcomes. Counselor-directed outcome is defined in this study as an event or process in which the counselor (a) initiated an intervention suggesting

referral and (b) directed the termination event and/or process. Client-determined outcome is defined as one in which the client ultimately controlled the outcome. All client-determined outcomes involved clients either overtly or covertly terminating treatment. Details about the processes leading to resolution and implementation of resolution are presented in the outcome category in Chapter 5. A summary of reported outcome type is given in Table 33.

As mentioned earlier in this chapter, boundaries of competence literature offers counselors the two options of continued treatment, which necessitates following ethics code requirements for training and supervision when entering new practice domains, and termination, which must be accompanied by suitable referral options. The data collected for this study divides easily into the two options of continued treatment and termination, but there is a more complex story being told underneath those options.

Continued Treatment

The literature appears to assume that continued treatment in boundaries of competence concern situations equates to entering a new practice domain, and ethics mandates related to entering new practice domains require counselors to seek relevant training and supervision in order to be competent in the new area of practice. The fact that none of the participants in this study reported any intention to seek additional training and supervision was addressed earlier in this discussion section within the therapeutic relationship area of consideration under counselor utilization of professional resources. Although none of the participants reported seeking or planning

to seek out training and/or supervision specific to the boundaries of competence concerns which initiated their decision-making processes, it could be argued that they were still within ethical guidelines. However, it could also be argued that they would have benefited by seeking out issue specific training related to continued treatment.

The emergent model encourages counselors who continue treatment as resolution to boundaries of competence concern situations to consider engaging in some form of continued training (e.g. workshops, issue-specific independent reading, and/or seeking supervision/consultation specific to the concern). At the same time, the emergent model recognized that not all resolutions for continued treatment in boundaries of competence concern situations place the counselor into a new practice domain situation. The model encourages counselors to consult with colleagues, assess each situation, and discern whether or not they have entered into a new practice domain. Even if counselors can offer a defensible rationale which demonstrates a new practice domain has not been entered, clinically skilled counselors still have a responsibility to address any areas in their training and/or experience that originally precipitated the concern. Therefore counselors may need to seek additional training and/or supervision to provide the best service to clients.

Termination

The data collected for this study clearly demonstrate that termination is not always a nicely packaged and counselor-directed process. The emergent model highlights the possibility that terminations may be client-determined or system-

directed. Participant stories indicate that they were not generally prepared for the complex dynamics surrounding termination and, in particular, those situations involving client and/or system-directed terminations. The emergent model, therefore, suggests that counselor educators and supervisors intentionally work with students and supervisees around the potentially complex dynamics of termination.

Ethics literature in general, ethics literature specific to boundaries of competence concerns, and the ethics codes all state that terminations with clients who need further work need to be accompanied by referral options. All counselor-directed terminations and the three client-directed terminations following counselor suggestion for alternate treatment options were accompanied by referral suggestions. The data suggest that counselors do couple termination and referral together in boundaries of competence situations and this can be taken as encouragement for those who train counselors and for leaders in the field.

Aftermath/Post-Outcome Reflection Area of Consideration

Post-outcome reflection is the final step in the emergent model interactive non-linear model. Data collected for this study does not leave this step as a mere recommendation or encouragement but requires counselors to engage in post-outcome reflection in order to complete the process of decision making. In other words, this step finishes the decision-making process and the process is not finished if the counselor does not engage in post-outcome reflection.

Participant data which emerged around post-outcome reflections include assessment of the clinical and decision-making processes, attending to feeling responses following resolution, and the use of reflection as a tool for professional growth. The single-point arrow line moving from the outcome area of consideration to the aftermath/post-outcome reflection area of consideration is intended to illustrate the potential impact of decision making on the counselor. The flow line also symbolizes the gathering of insights and knowledge encountered during the clinical and decision-making experience. These pieces can then be potential input for further professional growth.

Only six (Corey et al., 2007; Forester-Miller and Davis, 1996; Hill et al., 1995; Remley & Herlihy, 2005; Stadler, 1986; Welfel, 2006) of the twenty models reviewed for this study included recommendations for post-outcome reflection. Most of the models reviewed for this study end the decision-making process with implementation of the decision. Only two models recommended post-outcome reflection as an integral part of the decision-making process. Four other models included some discussion about post-decision reflection in their model presentation but did not include this step as an integrated part of the decision-making process.

Aftermath: Attending to Feeling Responses

The aftermath portion of the title for this area of consideration is a result of the label one participant gave his post-outcome process. The term also fit well with other participant accounts of the emotional impact their decision-making processes had on

their professional lives. Although there is some encouragement for counselors to attend to post-outcome feelings within ethical decision-making literature, there is nothing in the literature that communicates the powerful impact the process can have on counselor emotions.

Participants in this study described powerful emotional responses to their selected client cases. Some of the participants' emotional responses during the research interview were very evident in their tears, voice tones, body language, and verbal expressions. Three participants shared cases that were over a decade old, and yet, powerful unprocessed feelings came spilling out during the interview. Some noted that the conceptual mapping task had assisted them in processing circumstances and feelings they had not dealt with in all that time. The participant who gave the area of consideration its aftermath designator shared a more recent story, but had not sought counsel on how to deal with the complicated work and legal implications of his decision-making process.

The emergent model highlights this potential for significant emotional impact on counselors and encourages counselors to attend to such feelings with supervisors and/or through therapy. Counselor educators are encouraged to alert counselors in training to this possibility and to educate them about self-care strategies in the event of such difficult circumstances. Supervisors are advised to be aware of the potential negative impact on counselor emotions and professional growth and to assist supervisees with positive recovery options.

Growth Realized: Assessing Clinical and Decision-Making Process

The emergent model encourages counselors to spend time assessing their clinical and decision-making processes for learning and professional growth purposes. This encouragement is consistent with the recommendations made by Corey et al. (2007), Hill et al. (1995), Remley and Herlihy (2005), Stadler (1986), and Welfel (2006) in their model presentations. The four self-tests recommended by Remley and Herlihy in their model presentation are considered a good reference point for at least part of the evaluation process. This recommendation is also consistent with participant reports related to the benefits of reflection and the growth realized. Participants reported assessment of both the clinical and decision-making dimensions of their work with selected clients. It is also noteworthy that some participants linked their insights about professional growth to the research interview conceptual mapping task. More discussion is offered about the value of the CMT in the research tool section of this chapter

In summary, the emergent model is a research-based interactive, non-linear model for ethical decision making that has five major units called areas of consideration. Therapeutic relationship, supervision dynamics, system dynamics, outcome, and aftermath/post-outcome reflection are the five areas of consideration in this model. The core of the model, and its starting point, is the therapeutic relationship area of consideration. The aftermath/post-outcome reflection area of consideration is the end point, which is seen a necessary step to completion of the decision-making process.

Areas of consideration and elements contain information, encouragements, and cautions for counselors to consider during the decision-making process. Considerations for counselor educators and supervisors in training and supervising counselors also emerged from the data. Each area of consideration contains two or more primary elements with some of the primary elements containing secondary and tertiary elements. The model as an interactive whole, each of the areas of consideration, and all of the numerous elements emerged from the rich data gathered during fact-to-face interviews with 14 practicing professional counselors who volunteered for this qualitative grounded theory research study.

A comparison of the emergent model with relevant literature reveals similarities and differences. The therapeutic relationship area of consideration is not present in ethical decision-making models found in the literature. However, both of the primary elements and a number of the secondary elements within the therapeutic relationship area of consideration have parallels within the models reviewed for this study. The remaining four areas of consideration all have parallels within the models of ethical decision making found in the literature, but in each area there are dynamics present in the data which formed the model that are not present in the literature. The system dynamics area of consideration is the one area that is most dynamically different from the models found in the literature. Very little is said in the presentation of ethical decision-making models found in the literature addressing assessing and managing difficult system dynamics during the decision-making process.

PARTICIPANT REACTON TO THE RESEARCH TOOL

Participant feedback about the conceptual mapping task (CMT) coupled with the rich data generated in this study affirms the use of conceptual mapping for research, counselor training, and supervision. A volume of rich data was generated during the face-to-face interviews. The interview research tool was the CMT, introduced to counseling research by Martin et al. in 1989. Participants generally reported that the CMT was useful for reflection, insight, and/or learning. A number of the participants also stated they experienced the exercise as fun and/or enjoyable. There was an unanticipated positive energy present in most of the interviews that is somewhat captured in statements made by participants about their reaction to the CMT, but, additionally, there was an energy present that cannot be captured by words.

There was a general attitude of gratefulness on the part of the participants concerning the opportunity to work through a case using the CMT. It appeared that at least one participant used the CMT interview exercise as a consultation opportunity. Two participants reached a decision for resolution during the interview. Several participants remarked that the tool had generated reflection and/or insight about their clinical and decision-making processes. One declared that it was clarifying. Another said it gave her a new-found confidence. A number of participants spoke about gaining insights about themselves as they looked at their finished maps. Three participants seemed to find some degree of closure for old cases that had not been settled for them.

SIGNIFICANCE OF THE STUDY

The overarching significant results emerging from this study can be summarized in three separated but highly related contributions to the field of counseling.

- A research-based model for ethical decision making in boundaries of competence concern situations emerged out of the research data and thus the profession now has a research-based model for ethical decision-making. No other research-based models or models specific to boundaries of competence concerns were found in the literature. It is therefore assumed that the emergent model is the first research-based model for ethical decision making to be presented to the profession. It is also assumed that this is the first model specifically addressing boundaries of competence concern situations to be developed.
- As a result of this study the field of counseling now has research data giving insight into patterns of ethical decision making used by practicing professional counselors when encountering boundaries of competence concerns.
- The data generated by the 14 interviews conducted for this study informs the profession about (a) similarities between factors in ethical decision-making models and those of practicing professional counselors; (b) areas that are addressed by models found in the literature but are in some significant ways dynamically different in the real world of counselor application of ethics and ethical decision making; and (c) factors that the practicing professional

counselors who volunteered for this study used or experienced in their decision-making processes that are not present in the models they have to reference in the current literature. These similarities and differences are discussed in the literature comparison section of this chapter and summarized in Table 35 of that section.

CONCLUSIONS

The conclusions drawn from analysis of the data collected for this study using the CMT are divided into six sections. The first five directly correlate to the five areas of consideration or major units in the emergent model. The sixth section relates to the research tool used for data collection. Before listing conclusions from the various divisions of the data, five overarching conclusions about the model are offered.

- The emergent model, in many ways, offers encouragement to counselor educators and other leaders in the field of counseling because patterns of decision making parallel rather than contradict the standards set by ethics codes, general ethics literature, boundaries of competence specific literature, and models of ethical decision making found in the literature.
- Differences between factors for consideration in the decision-making process as presented in the emergent model and factors encouraged in models of ethical decision making found in the literature are related to dynamic emphases and understandings that resulted from interactions between counselor and client, counselor and supervisors, and counselor and system dynamics.

- The data demonstrate that practicing professional counselors include several factors for consideration in ethical decision making not present in ethical decision-making models in the literature (e.g. influence of client approach to treatment, attending to the working alliance, evaluating and attending to the potential impact of supervision dynamics, and understanding that sometimes outcomes are client determined and implemented).
- Ethical decision-making patterns of practicing professional counselors are generally relationally interactive and non-linear but there are exceptions to the rule.
- Interactive dynamics between counselor and client, counselor and supervisor, and counselor and system dynamics have the potential to skew the decision-making process.

Therapeutic Relationship Area of Consideration

- The therapeutic relationship is the start point and core of the decision-making process for practicing professional counselors. As the core area of consideration, the therapeutic relationship contains and is impacted by more flow lines than any of the other components.
- Speaking of clients in a human and gracious manner that is professional and yet relationally caring is a distinctive characteristic of the participants interviewed for this study and perhaps of counselors in general.

- Consideration of client background and context is a fundamental factor of consideration in the decision-making process. Because of the emphasis on consideration of client background, as well as client presentation and approach to the therapeutic process, the emergent model is considered applicable to multicultural situations, and, when used by counselors who are multiculturally competent, provides guidance that can enhance multicultural sensitivity.
- Clients' presentation and approach to treatment can precipitate an awareness of a boundaries of competence concern and, additionally, may impact the ethical decision-making process.
- Counselor professional training and ongoing development are foundational to sound ethical decision making.
- Counselor emotional responses play a role in the clinical interactions and ethical decision-making processes.
- Counselor virtue or lack of virtue impacts the ethical decision-making process.
- Identification of concern is a factor in the emergent model. Realizing that identification ranges from a point-in-time realization to a slow and subtle process of growing awareness is fundamental to a complete understanding of this factor.
- Analyses of the data generated during the face-to-face interviews conducted for this study suggest that counselors are not utilizing professional resources in the process of ethical decision-making. It is clear from the data that counselors have some knowledge of professional ethics code standards, engage in

professionally related independent reading, and participate in continuing education opportunities. They report valuing independent reading and profit from continuing education experiences. However, they do not appear to link these activities to their ethical decision-making processes.

- The working alliance or developing, considering and/or working out of the strength of the therapeutic relationship is a factor in decision making. The presence or absence of a working alliance significantly impacts the process of decision-making, and thus, it is necessary for counselors to have an awareness of the role of the working alliance.
- Counselors do not do action steps in a neat and tidy manner. Action steps in the ethical decision-making process are a multilayered web of considerations, decisions, and interventions.

Supervision Dynamics Area of Consideration

- Supervision or clinical guidance is an important component of decision making but can skew the process and may have a potentially important negative or positive impact on the counselor, client, outcome, and aftermath/post-outcome reflection. Therefore, evaluation of the impact supervision is having on the decision-making can skew the process and may have a potentially important negative or positive impact on the counselor, client, outcome, and aftermath/post-outcome reflection. Evaluation of the impact supervision is

having on the decision-making process, client, and counselor sense of self is an important step in the decision-making process.

System Dynamics Area of Consideration

- Although not all boundaries of competence concerns ethical decision-making processes are affected by system dynamics, the data collected for this study model highlight the need for counselors to be aware of the potential role negative and/or positive system dynamics can play in the decision-making process.
- Negative system dynamics negatively influence the dynamics of the therapeutic relationship, adversely impact outcome for both clients and counselors, and contribute to difficult, if not painful, aftermath/post-outcome reflection processes.
- Positive system dynamics impacted the therapeutic relationship by creating supportive, ordered, facilitating, and responsive environments that were considerate of all parties involved in the delivery of services.

Outcome Area of Consideration

- Complex situations, struggles, and strategies lead to a variety of outcome scenarios, including the reality that counselors do not always control selection of outcome action. Clients sometimes select to declare their intent to terminate or just do not make or attend appointments.

- Counselors do not necessarily see all situations involving boundaries of competence concerns ending in a continued treatment resolution as necessitating adherence to new practice domains ethics standards.
- The data suggest that counselors do couple termination and referral together in boundaries of competence situations and this can be taken as encouragement for those who train counselors and for leaders in the field.

Aftermath/Post-Outcome Reflection Area of Consideration

- The title of this area of consideration intentionally alerts counselor educators, supervisors, and counselors to two significant post-outcome dynamics: (a) the potential outcome dynamics to create significant struggles and feeling responses for counselors, and (b) the need for and value of post-outcome reflection.
- Post-outcome reflection is the final step in the decision-making process. It is not a recommendation or encouragement but a required part of the entire decision-making process. In other words, this step finishes the decision-making process and the process is not finished if the counselor does not engage in post-outcome reflection.
- It is the interactions between client and counselor, supervisor and supervisee, system and therapeutic relationship that impact and sometimes determine the nature of aftermath/post-outcome reflections.

Research Tool

- The conceptual mapping task is a valuable tool for research, counselor training, and supervision.

IMPLICATIONS

The implications of this research are drawn from analysis of the data collected for this study using the conceptual mapping tool (CMT) and are divided into six sections. The first is the therapeutic relationship area of consideration. The second combines the supervision and system dynamics areas of consideration. The third and fourth note implications related to outcome and aftermath/post-outcome reflection areas of consideration. The fifth relates to the research tool used for data collection. The six offers suggestions for future research. Before listing conclusions from the various divisions of the data, two implications related to the interactive non-linear nature of the model are offered.

- Given the dominate demonstration of interactive non-linear decision-making patterns in this study, counselor educators and supervisors might find it advantageous to tap into that problem-solving style when training for clinical/ethical decision making and/or supervising counselors who are struggling through complex ethical decision-making situations.
- Counselors need to be encouraged and trained to see the decision-making process as interactive both externally and internally. The external process involves interactions between participants and other parties involved in the

process (e.g., clients, supervisors, and systems). The internal process involves counselor internal thinking and feeling processes generated by unfolding client stories, supervisor information or actions, and system dynamics that are informed by professional knowledge gained in master's-level academic training, continuing education, and clinical experiences. This training for the reality of what they will encounter in the field may help normalize the complex and often daunting process of complex decision making.

Therapeutic Relationship Area of Consideration

- The data imply that counselor educators need to prepare counselors in training to be aware of the influence client dynamics may have on the decision-making process.
- Supervisors are advised to keep a watchful eye for how the decision-making process is being skewed by client dynamics and/or counselor feeling responses and guide supervisees accordingly.
- Ethical guidelines require counselors to seek supervision and training when engaging in new practice domains. The data reveal a lack of supervisor encouragement to research relevant literature and/or seek out continuing education opportunities in new practice domain situations. Consequently, counselors, counselor educators, and supervisors are encouraged to attend carefully to this ethics mandate in practice, training, and supervision settings.

- The data suggest that counselor educators and supervisors need to offer more instruction and/or direction to counselors in training and supervisees around the value of researching literature relevant to boundaries of competence concern issues, seeking out continuing education workshops, and consulting professional organization legal and ethics resource personnel when engaging in an ethical decision-making process.
- The data suggest that counselor educators and supervisors might consider the need for training and supervision interventions that will assist counselors in training and/or supervisees to fully understand and consider the impact of counselor termination and referral on clients and/or their social support systems.

Supervision and System Dynamics Areas of Consideration

- If it is true that to be forewarned is to be forearmed, then knowing the potential power and impact supervision and system dynamics and interactions can have on the decision-making process and parties involved would be immensely valuable to counselors in training. Knowing ahead of time the kind of dynamic other counselors have experienced could, at the very least, reduce stress by normalizing the often cumbersome and hazardous decision-making process. Therefore, one implication of this study is that counselors in training would benefit from being exposed to the potential impact of supervision and system

dynamics on the decision-making process that will assist them in developing decision-making skills.

Outcome Area of Consideration

- The data collected for this study clearly demonstrate that termination is not always a nicely packaged and counselor-directed process. The data suggest that participants were not generally prepared for the complex dynamics surrounding termination, and, in particular, those situations involving client- and/or system-directed terminations. It is therefore suggested that counselor educators and supervisors intentionally work with students and supervisees around the potentially complex dynamics of termination.

Aftermath/Post-Outcome Reflection Area of Consideration

- The data highlights the need for counselors and supervisors to attend to the potential feelings of emotional distress that can be encountered when one is involved in difficult decision-making processes.
- The data suggest that complex ethical decision-making situations can have a significant emotional impact on counselors. Counselors are encouraged to attend to difficult feeling responses with supervisors and/or through therapy. Counselor educators are encouraged to alert counselors in training to this possibility and to educate them about self-care strategies in the event of such difficult circumstances. Supervisors are advised to be aware of the potential

negative impact on counselor emotions and professional growth and to assist supervisees with positive recovery options.

Research Tool

- The data suggest that the conceptual mapping task (CMT) is a valuable tool for research, counselor training, and supervision. Therefore research using the CMT is recommended for use in counseling research striving to understand conceptual dynamics related to the counseling process. The CMT is also recommended for counselor training and supervision as a tool to assist counselors in training and practicing counselors to conceptualize ethical decision-making processes.

Future Research

- It is believed that the emergent model is compatible with multicultural competence concerns situations. However, the research design did not call for intentionally selecting counselor/client situations that were multicultural by nature. A replication of this study which will select for multicultural counselor/client dynamics including non-traditional counseling model situations is recommended.
- It is believed that the emergent model is generalizable; however, the client sample was geographically limited. Therefore, it is recommended that the study be replicated using a national population.

- Each individual area of consideration in the emergent model is derived from significant data collected for this study. It is recommended that further research be done to examine each of the individual areas of consideration.

LIMITATIONS OF THE STUDY

The perceived limitations of this study are listed below in bullet-pointed format. The listed limitations relate to design and include consideration of participant ability to identify a boundaries of competence concern, acknowledgement of possible participant memory alterations, possible implications of geographical limits, and effect of researcher on generation of research data. Additionally, it is recognized that this data only relates to counselor-reported experience and does not include client-reported experience.

- Participants needed to have an awareness of boundaries of competence issues and be able to identify their limits in at least one clinical experience. This was not a study to determine if counselors are aware of and/or can identify boundaries of competence issues. Therefore, the study does not address the issues of a general understanding of boundaries of competence among practicing professional counselors.
- It is acknowledged that each participant reported the stories of her or his selected clinical case that were impacted by their individual personal and professional experiences, professional training and level of development,

and/or personal values and internalized virtue. Additionally, it is impossible to measure the degree of real memory disturbed by time.

- This study did not involve a national search, and, consequently, there may be inherent limits in the geographically restricted sample.
- It is acknowledged that researcher presentation and skill level may have impacted participant responses and contributed to what is called the "Hawthorne effect" (Cook & Campbell, 1979, p. 39).
- This was not a client outcome study and, therefore, there is no way of knowing client experience of the reported decision-making processes.

SUMMARY

Fourteen practicing professional counselors in the state of Illinois volunteered for this study. They told stories of ethical decision making that were professionally difficult. It took courage to invite a researcher into the privacy of their therapeutic experiences. Their courage has yielded rich data and provided the profession with a window of insight into the patterns of ethical decision making practicing counselors engage in when encountering boundaries of competence concern issues.

The end result of grounded theory qualitative research is the development of theory. In this study the theory is a model of ethical decision making. It is assumed that the emergent model is the first research-based model to be offered and the first model of ethical decision making specific to boundaries of competence concerns. The data and consequent model are full of insights for the profession about how practicing

professional counselors approach ethical decision making. Some of the data add to the current teaching about ethical decision making and some of it affirms that counselors in the field do generally conduct decision making in a sound ethical manner. Participants communicated a commitment to attending to their boundaries of competence, upholding ethical standards, working out of understood moral principles, and considering client context by demonstrating contextual sensitivity.

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APPENDIX A

PARTICIPANT SELECTION

INITIAL RECRUITMENT FLYER

AND

RESPONSE POST CARD

Front Cover Invitation Flyer

--------¤ ¤ ¤--------

Professional Counselors
do important work
and have significant
insights to share

You are being invited
to
contribute
to
the profession
through sharing
the process
of your work

--------¤ ¤ ¤--------

Left-Inside Page of Invitation Flyer

What is this opportunity?

This is an opportunity to contribute to the profession through participating in a research interview.

What will I have to do?

- ✓ Indicate your interest by responding
  to this invitation by:
  - ❑ returning the enclosed postcard,
  - ❑ or initiating either a phone call or an email
    to the number or address listed
    at the end of this invitation.
- ✓ Participate in a 15 to 20 minute phone interview
  to be scheduled at your convenience.
- ✓ Be willing to spend 1 to 1 ½ hours in a face to face interview
  to be scheduled at a time and location convenient for you.

Will there be a benefit for me personally?

As a research participant, you will be involved in an interview activity that will be a rewarding experience and may produce insights which could enhance your clinical work.

What will be the benefit to the profession?

The stories and information gathered will assist other professionals in the clinical process of decision making when confronted with difficult, ethically-conflicting and confusing clinical information. Additionally, it is hoped this research will help inform training modalities for preparing new clinicians.

Right-Inside Page of Invitation Flyer

If I tell my story, will the information be kept confidential?

YES! Because data will appear as a collection of pieces, nothing in the reporting of the data will identify you, your story, or your client's story.

What is the research about?

This research project will explore the therapists' struggle when a client's presentation causes the counselor to ask, "Am I over my head with this client situation?"

No mental health professional can, by training or through experience, be completely prepared for every challenge presented in the clinical setting.

The question of this study is:

What is the process that the professional counselor engages in when confronted with the questions involved in client commitment and professional limits?

Who is conducting the research?

The research is being conducted by Linda Leitch-Alford . Linda has maintained a private practice in the state of Illinois for over 18 years, is a Licensed Clinical Professional Counselor, and a doctoral candidate at Northern Illinois University.

As a fellow professional counselor, Linda has had to ask the "am I over my head?" question many times during the course of her clinical life. She has struggled with the difficult, complex and sometimes conflicting ethical standards, as well as the pragmatics of reality, which often accompany these situations.

Back Page of Invitation Flyer

How do I get involved?

- ✓ Fill out and return the enclosed post card in tomorrow's mail.
- ✓ Or pick up the phone, call 847.362.4863 and leave your name, your phone number and some times that might be convenient for a return call.
- ✓ Or send an email to t.l.alford@worldnet.att.net indicating you interest.

As soon as a communication is received from you, Linda will call you to set up a time for the initial phone interview.

What if I have questions?

Your questions are welcome. You may contact Linda at 847.362.4863 or by email at t.l.alford@worldnet.att.net.

You may also contact her faculty advisor, Dr. Toni Tollerud, at Northern Illinois University. Dr. Tollerud can be reached by phone at 815.753.1193 or by email at tollerud@niu.edu.

I want to personally thank you for giving consideration to this research project

Linda Leitch-Alford

Initial Response Post Card

Linda Leitch Alford
LakeSide Center for Counseling
41 E Main St. Suite 104
Lake Zurich, IL. 60047

____ I am interested in contributing to the profession through sharing in this study.

Name: _____

Phone # _____

Best time(s) to contact you: _____

APPENDIX B

PHONE-SCREEENING INTERVIEW OUTLINE FORMAT

Appendix B

Phone-Screening Interview

It is intended that the format presented in this appendix will be used to provide consistent structure to the phone-screening interview throughout the participant selection process. The items in bold type are to be read to the potential participant by the researcher. Charts and blank spaces are intended for the convenience of the researcher for notation and tracking during the phone-screening interview.

Information in this box is to be filled out prior to the interview

Interviewee name _____ Date _____

Address _____
Street

_____ _____
City Zip Code

Gender: ___Male ___Female License List: ___LPC ___LCPC

Introduction and Greeting

After a brief exchange of social greeting, begin each interview with the following greeting.

I would like to thank you for responding to the information flyer for this study and taking time for this short phone interview. The phone interview is designed to help collect information on the training, credentials, experience and professional setting for each counselor interested in participating in the study. This interview will take only fifteen to twenty minutes. I will be asking you a number of short demographic questions that will require only one or two word responses as well as several discussion questions that will require you to briefly discuss some aspect of your professional work world. Shall we begin?

Section I: Education

I would like to begin by asking you about your education and your professional credentials.

1. **What degree or degrees have you earned that qualify you to practice as a professional counselor?**

_____ Masters in _____
_____ Doctorate in _____
EdD PhD PsyD

_____ Other _____

2. What was the year of graduation for this degree (or these degrees)?

Masters _____
Doctorate _____
Other _____

Section II: Credentials

1. What license or licenses do you hold that enable you to practice as a mental health professional?

___LPC ___LCPC ___Licensed Marriage and Family Therapist

___ACSW ___LCSW ___Licensed Clinical Psychologist

2. What other professional credentials do you hold?

_____

_____

Section III: Practice Setting

I would now like to ask you about your practice setting and experience.

Practice Setting

1. In what setting or settings have you worked as a professional counselor (marriage and family therapist, social worker or psychologist if indicated by information under credentials)?

2. **Approximately how many years have you been doing clinical work?** _____

Have those years been full time, part time or a combination of full and part time? _____

_____

Section IV: Boundaries of Competence Awareness

1. **Just a few more questions left. This one has some introductory remarks but requires only a simple yes or no answer.**

   We know that it is impossible for training programs to prepare counselors for the wide scope of client situations that can be presented in counseling sessions. Sometimes even experienced counselors report that they find themselves faced with complex situations in which they question if they are over their heads. In your clinical work, have you ever encountered a client that caused you to wonder whether or not your training, skills and/or experience were adequate or best for a particular client?

   YES NO

   NOTE: Although this is a closed question, the interviewee might begin to tell a story about a boundaries of competence concern. If this happens gently guide the interviewee by saying, "I am sure your story is very important and I would very much like to hear it if we schedule a full interview but for now, I must move us on to the end of the interview."

If the potential participant responds with a yes to question number one in this section, then ask question number two of this section. If the individual responds with a no to question number one in this section, then proceed to section VI: Ending the Interview.

2. **In the clinical work setting or settings where you have encountered concerns about your training, skill and/or experience level, what freedoms and/or limitations have you encountered when making treatment decisions concerning continued treatment? For instance, have you been allowed to struggle with a particular client issues until *you* decided to change treatment strategies or did your supervisor or employer require that you terminate the clinical relationship because of agency or institutional policy?**

Section V: Experience and Style

I am wondering if you would talk a bit about your clinical style as a professional counselor (marriage and family therapist, social worker or psychologist if indicated by the information under credentials); If they need a prompt, use: your theoretical orientation or your relational style with clients.

Section VI: Ending the Interview

You will have one of three scenarios at this point in the interview and must make one of three choices.

A. Interviewee does not meet the criterion for the study. If the interviewee does not meet the criterion for the study, thank him or her for their time and efforts and tell them that you will contact them later about their further involvement in the study.

B. Placing interviewees on a reserve list. The reserve list will assist in holding potential participants who meet the criterion for the study while you are screening additional respondents. If you wish to place the interviewee on the reserve list say:

> **I want to thank you again for your time and efforts to this point. At different points in the study, I will need to do a lengthy interview with participants who have various professional work settings and experience. I will be creating a reserve list for individuals who have participated in the phone interview and qualify for the study. I will contact these individuals from the list to schedule a face to face interview as the study proceeds. I would like to include your name on the reserve list, would that be OK with you?**

If yes, thank the interviewee for this courtesy and assure them that they will hear from you in the next several months.

If no, inquire about the reasons with the hope of keeping them engaged, thank the interviewee for their time and end the interview.

> NOTE: In the case of A or B, when you are sure that the interviewee will not be called for an appointment, send a letter of thanks and formally end their involvement in the study. In the case where the interview is held on the reserve list for more than two months, send a post card acknowledging that the study is still in process and stating that they may be getting a call requesting a further interview in the near future.

C. Scheduling an appointment. When it is clear that an interviewee qualifies for the study and scheduling an appointment is indicated, say:

> **I would like to make an appoint for a face to face interview that will take no more than 1 hour and 30 minutes with you. I will meet you at a time and location that is convenient for you. Would you be willing to meet with me for this interview?**

If the answer is yes, work through the details of scheduling the appointment.

If the answer is no, ask:

> **"Is there anything I can say or do to make the interview an option for you?" and depending on this answer either proceed to schedule the face to face interview with the individual or graciously end the interview.**

APPENDIX C

INFORMED CONSENT FORM

Informed Consent Form

RESEARCHER: Linda Leitch-Alford
41 E. Main Street Suite 104
Lake Zurich IL 60047
847.540.9625
t.l.alford@worldnet.att.net

SUBJECT: ____ LPC ____ LCPC

_____
Participant pseudonym

_____
Client pseudonym

As a doctoral student in Counselor Education at Northern Illinois University, I want to thank you for agreeing to participate in this study. This form will outline the purposes of the study and provide information about your involvement and rights as a participant.

The purposes of this study are:

1. To fulfill the dissertation research requirement for my doctorate in Counselor Education from Northern Illinois University
2. To obtain field data and gain insight concerning the ethical decision-making process that the professional counselor engages in when faced with a boundaries of competence concern
3. To report to the profession about the ethical decision-making process in which the professional counselor engages to resolve boundaries of competence concerns

The data for the study will be collected in a single face-to-face audiotaped interview. Each interview will be a maximum of one and one-half hours and will include a conceptual mapping exercise. The interviews will be conducted with a minimum of twelve licensed counselors in the state of Illinois. However, participants will continue to be selected and interviewed until the researcher finds that the data has begun to repeat itself.

I encouraged you to ask questions at any time about either the nature of the study or the interview process. Your concerns and suggestions will be taken seriously. Please feel free to ask questions during the interview or contact me at the address, email or phone number listed above following the interview. You may also address your concerns with my advisor, Dr. Toni Tollerud who may be reached by phone at 815.753.9311 or email at tollerud@niu.edu. If you wish further information regarding your rights as a research subject, you may contact the Office of Research Compliance at Northern Illinois University (815.753.8588).

The information collected during the interviews will be reported in a form that will not in any way identify you or your client. The data will be used to complete my dissertation and to inform the profession through presentation and publication in professional journals. No information you reveal in this interview process will be used to limit or affect your practice in any way.

There is some possibility that recalling a case in which you experienced a boundaries of competence ethical dilemma might cause you some emotional discomfort or distress. Should this distress become too uncomfortable, please feel free to discontinue the interview. Following the interview, you are encouraged to use your regular supervision format and/or the members of your professional network should you feel the need to process any discomfort that emerges.

I guarantee that the following conditions will be met:

1. Neither your name nor the name of your client will be used in the reporting of the data. Any potentially identifying information that is revealed during the interview will be deleted from the reporting of the data or reported solely in aggregate form. You are asked to select a pseudonym for yourself and your client for data reporting purposes.
2. All audiotapes will be destroyed at the completion of the study.
3. Your participation in this research is voluntary. If you do not want to answer a specific question, you may request that the researcher skip to the next question. You have the right to withdraw at any time, for any reason, without any prejudice. Should you choose to stop the interview or request that your data be withdrawn from the study after the completion of the interview, all information collected from you will be returned to you or destroyed as per your request.
4. A copy of the dissertation will be available, if you wish to review it.

I have read, understand and agree to the terms stated above.

Participant _____ Date _____

In addition to the requesting your general permission in regards to the above terms, I would like to ask for specific permission for audiotaping.

YES, I give permission to be audiotaped.

Participant _____ Date _____

NO, I do not give permission to be audiotaped.

Participant _____ Date _____

I agree to the terms stated above and will adhere to the participant's wishes in regards to audiotaping.

Researcher _____ Date _____

APPENDIX D

CONCEPTUAL MAPPING INTERVIEW

FOUR-PHASE INTERVIEW FORMAT

It is intended that the format presented in this appendix will be used to provide consistent structure to the interview throughout the data collection process. The audio-taped face to face four-phase interview will be between one and one and a half-hours in duration. The items in bold type are to be read to the interviewee by the interviewer. Charts and blank spaces are intended for the convenience of the interviewer for notation and tracking during the interview.

Interview Phase One: Individual Counselor Data

Introduction and Greeting

The interviewer will engage in a short informal greeting to relax the interviewee and begin the interview and then begin the formal interview by saying:

This is a four-phase interview that will last between one and one and a half-hours. I want to thank you for being willing to take the time and put forth the effort necessary to participate in this study. During the first phase of the interview, I will ask you some brief questions about your education, training and professional life that will require only short factual answers. In phase two, I will ask you to review a client case and in phase three you will have the opportunity to do an exercise that will utilize the information you have generated in phase two. During phase four, we will have a brief time for you to add additional comments and, if necessary, for me to ask questions to help further my understanding of any pieces from phase two and/or phase three that may still be unclear for me. Shall we begin?

Education

I just want to quickly review the course work you had in your masters program and the other professional educational opportunities you may have participated in outside of your master's degree.

The first set of questions is about the training and course work you took *within* in your master's degree training.

I will name a *training content area* and would like you to indicate if this training content was part of your master's degree. I will then prompt you to rank this content area between one and five with

> ***one* indicating that you have *not* found the content area or training *helpful* in your practice of professional counseling,**
>
> ***three* indicating that the area was *somewhat helpful,* and**
>
> ***five* indicating that you have found the content area or training to be *very helpful* to your practice of professional counseling. Ready?**

Training Area	Course Taken within Masters Program		
	Yes	No	Rating 1 2 3 4 5
Counseling Skills and/or Techniques			
Theories of Personality			
Legal & Professional Issues			
Professional Ethics			
Marriage and Family			
Group Counseling			
Diagnosis (Using the DSM)			
Dynamics of Addictions			
Testing and Assessment			
Multiculturalism			
Career Counseling			
Practicum			
Internship			
Area(s) of specialization			

Now I would like to do the same thing all over again but in relation to training you may have engaged in *beyond your masters degree* either in further formal academic training or in informal settings such as independent reading, seminars or workshops.

I will name a content area and simply want you to indicate if you have engaged in any continuing education training in that area and if that training was independent study or a more formal setting. I will then prompt you to indicate what the setting was if it was an academic course, seminar or workshop. I will also ask you to indicate the approximate date you engaged in the training. Ready?

Content Area Focus of Continuing Education Training	Training Format		
	Independent study	Seminar or Workshop (Other)	Approx. Training Date
Counseling Skills and/or Techniques			
Theories of Personality			
Legal, Ethical & Professional Issues			
Marriage and Family			
Group Counseling			
Diagnosis (Using the DSM)			
Multiculturalism			
Career Counseling			
Dynamics of Addictions			
Testing and Assessment			
Have you engaged in other training not covered to this point?			

Experience

I have already gathered some information in our phone interview about your practice setting(s) and length of service as a professional counselor, and I feel like I have a bit of a handle on your professional life. So in regards to your professional experience, I would just like to explore just two additional areas. These areas are geographical location and supervision. OK?

A. Geographical Location

As a researcher, I am interested in the difference in dynamics that might emerge for therapists who serve clients from differing geographical areas such as rural and metropolitan population centers. In this study this distinction will be determined based upon the US Census Bureau map that indicates which counties in the state of Illinois are to be considered rural and which are to be considered metropolitan. *From which county or counties in the state of Illinois do you draw your clients?*

_____ _____ _____ _____

If you needed to refer a client to another agency or counselor, would this generally create a logistical hardship for your clients? YES NO

Please briefly explain your situation in this regard?

B. Supervision

1. **How frequently do you attend individual supervision?**
   Prompt if needed: Weekly; Twice a Month; Once a month; As Needed; Never

2. **How frequently do you attend group supervision?**
   Prompt if needed: Weekly; Twice a Month; Once a month; As Needed; Never

3. **I would like you to use that 5 point scale again with one equaling not very helpful, three being somewhat helpful and five meaning very helpful. How helpful is individual supervision for you?** 1 2 3 4 5

4. **Using the same ranking scale, How helpful is group supervision for you?** 1 2 3 4 5

5. **Do you fill the role as a Supervisor?** YES NO
   If yes, ask: **Would you give a brief description of your role as a supervisor.**
   If no, move to the next section.

Theoretical Orientation

The final section in phase one deals with your theoretical orientation. I am going to hand you a list of theories and ask you to indicate the one or ones that you most strongly identify with in your clinical work. I have left a blank for other in case I missed a theory that is important to your work. Please choose *no more than three* and rank order those you choose marking number 1 as the most dominate in your work. Of course if you have only one, you may simply check that one.

Theoretical Orientation Checklist

_____ Psychoanalytic	_____ Jungian
_____ Adlerian	_____ Ego Psychology (Object Relations or Self Psychology)
_____ Rogerian	
_____ Existential	_____ Gestalt
_____ REBT	_____ Cognitive Behavioral
_____ Solution Focused	_____ Feminist
_____ Systemic	_____ Narrative
_____ Other _____	

Interview Phase Two: Review of Client Case

The selection of the client case illustration.

1. The interviewer will ask the following question:

   I would like you to think of one client case where, in the course of doing individual treatment, you became aware that you had just heard or had been hearing a client concern that was outside of your experience and/or training level.

2. The idea here is to encourage the participant to give a very brief overview of the case using the following question. (This free association task can take up to 15 minutes.)

   I would like to ask you to take about 15 minutes to tell me the full story of your journey to resolve the concern you had with this client. I would like you to begin at the point you first became aware of your limits to treat this client and continue your story through the process of continued treatment, the termination, and/or referral of this particular client.

NOTE: During this free association time, the interviewer is to remain silent and record the participant's responses on 1 and 7/8 inch by 2 and 7/8 inch Post-it® notes.

3. When the participant has concluded the free association section, the interviewer will show him or her the records on the Post-it® notes and ask the individual to review them. The interviewer will check with the participant to insure accuracy of listening and recording of the participant's case review.

Interview Phase Three: Creating the Conceptual Map

During the third phase of the interview the interviewee will be asked to create a conceptual map using the Post-it® notes generated during the second phase of the interview. You will need to give the participant a large lap–board containing a 24 by 22 inch sheet of newsprint and ask him or her to arrange the Post-it® notes into a conceptual map that shows how the concepts are related using the following steps:

1. Spatial representation arrangement

   I would like to ask you to take the Post-it® notes you have just reviewed and arrange them into a spatial representation of the process you have described through your story.

2. Indicating directional flow

   Now that you have arranged the Post-it® notes on the board, I would like to ask you to draw lines that connect the concepts and/or demonstrate the flow of the process they have described. I would like to encourage you to indicate the flow of the process by use of arrow points on the lines or by some other means that you feel clearly communicates any directional movement within the process.

3. Grouping Concepts

   I would like to ask you to find groups of concepts that you perceive belong together and draw a circle around each group of concepts to form clusters of concepts.

4. Labeling the Concept Clusters

   Finally, I would like to ask you to label each of the concept clusters you have created.

NOTE: It is important for the researcher to remain silent while the participant takes the time she or he needs to arrange the notes into spatial representation, draw the flow lines and determine the clusters and their labels.

Interview Phase Four: Wrap Up

The forth and final phase of the interview follows the unstructured interview format.

1. At this point ask the participant to reflect on her or his experience of the CMT and invite them to offer any final observations or thoughts. Ask:

    a. **Do you have any reactions to the conceptual mapping task that you would like to share**?

    b. **Is there anything you want to add to the ideas you have already shared?**

2. During this phase of the interview the you may, if necessary, also make further inquiry concerning the participant's conceptual map, as well as their process of decision making and treatment or referral to explore further clarification or insight. This portion of the forth phase will give opportunity for the researcher to explore any emerging but incomplete issues from phases two and three. The goal of this exploration is to seek clarification of concepts presented by the participant in the case presentation or the creation of the conceptual map.

3. The interview will end with the following statement containing final information about the reporting of the data and a word of thanks from the researcher. Read the following statement:

    I am very grateful for your participation in this study and appreciate your sharing your story with me. I want to say again that the data we have recorded via audio-tape and on this large piece of paper will be reported in a way that protects your privacy and the confidentiality of your client. The reporting of the data will be about your process and not about your particular client. If at anytime in the coming weeks, you become concerned about this matter, please feel free to contact me. Again, thank you for your participation and giving me the privilege of hearing your story.